JOURNAL OF THE

SOCIAL WORK

NATIONAL ASSOCIATION OF SOCIAL WORKERS

VOL. 6, NO. 3, JULY 1961

SOCIAL WORK

JOURNAL OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

SOCIAL WORK is a professional journal committed to improving practice and extending knowledge in the field of social welfare. The Editorial Board welcomes manuscripts that yield new insights into established practices, evaluate new techniques and researches, examine current social problems, or bring serious, critical analysis to bear on the problems of the profession itself. The occasional literary piece is gladly received when it concerns issues of significance to social workers.

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Published in January, April, July, and October.

Subscription rates: $6.00 per year, $1.75 per single copy. Half-rates to students in schools of social work.

Publication office—49 Sheridan Ave., Albany 10, N. Y.

Editorial and business office—95 Madison Avenue, New York 16, N. Y.

Second class postage paid at Albany, N. Y.

Volume 6, Number 3, July 1961

Optimum length for articles is 14–16 typewritten pages, double-spaced, or approximately 3,500 words. One article in each issue is selected by the Publications Committees of each of the following NASW Sections: Group Work, Medical Social Work, Psychiatric Social Work, School Social Work, and Social Work Research. Manuscripts and correspondence concerning Section space should be sent to the Managing Editor or appropriate Section Editor (see above). For proper consideration, authors should submit three copies of their papers, one of which must be an original typewritten copy.

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Editor's Page

To us, the constant barrage of articles, both published and unpublished, which worry about status, criticize complacency, lament inaction, suggests that social work is understandably one of the least complacent, possibly the most "shook up" of all the professions.

And why not, and perhaps for some of the same reasons that the United States is so "shook up" in world affairs. To an extraordinary degree the social work public conscience seems to reflect the American public conscience—which Eric Sevareid says is the guiltiest and toughest of any nation's. The United States expects of itself and is expected by others to take leadership in a world of intransigeant politics, where four out of five people do not have a square meal, about the same number have no health care, and the illiteracy rate is horrifyingly rising. If in the midst of snarling criticisms, frustrations, and failures the United States seems too often to be trying to solve everything at once, so do some social workers seem to want the profession to ride off in all directions in the name of social action.

It is true that social work has been threatened in some of its oldest and deepest convictions, namely, our belief that a health and decency standard of living can be achieved and the brotherhood of man become a reality, which is the more difficult because, as every social worker knows, these goals and methods are inextricably intertwined. Frustrations and failures are the more galling because the very methods of social work were hammered out of democratic principles and processes which in our innocence we believed should operate effectively anywhere. Now the world is confronted by monolithic structures, problems being solved in totalitarian fashion with many peoples apparently liking their lot. For social workers the picture is even more disturbing when one sees the top echelons of our own government often disregarding principles and practices which have been tested out on the North American continent for nearly a hundred years—since the old Poor Laws began to give way to progressive welfare development.

To take the single instance of attempts at world relief-giving. No doubt the basic principles of assistance are not so familiar to the average college quiz master as is the second law of thermodynamics, but one would think that top-level administrators would inform themselves about some of the obvious things before launching assistance programs. To mention only a few such items, from tested experience:

Relief (assistance) should be given on the basis of need, not because of race, creed, color, political affiliation, or even one kind of cultural "morality." Even if the best of the missionaries had not found this out, even if Drs. Dooley and Schweitzer didn't magnificently practice it, even if the Friends had not made it a cardinal tenet of their helping services, even if social workers hadn't been largely responsible for writing it into state and federal policy—one would have thought that administrators might have learned that rice does not make Christians nor wheat converts from communism! It has been hard to convince this most generous of nations, which tolerates so easily the racketeer, that the child of the unwed mother needs full social security protection. Yet this struggle chiefly carried on by social workers is no more than half won, and let no one underestimate its importance.

Another "principle" is that *relief in kind, unless very carefully administered, does more harm than good.* Well enough in emergencies and before better planning can be done, it tends to upset not only family but national economies. The Care package sold on the black market, the private airport built in one of the poverty-stricken countries in Latin America, are perhaps no worse than the carload of prunes sent to a New York village and

(Continued on page 128)

BY JACKSON TOBY

Early Identification and Intensive Treatment of Predelinquents: A Negative View

THE "EARLY IDENTIFICATION and intensive treatment" approach to delinquency control is breathtakingly plausible. This explains its popularity. A plausible argument is not necessarily correct, as Columbus showed those who believed that the world is flat. "Early identification and intensive treatment," though probably not as erroneous as the flat-world theory, is more a slogan or a rallying cry than a realistic assessment of the difficulties that delinquency control programs must overcome. This paper will attempt to analyze the need for sharper definition of the implicit assumptions of early identification and intensive treatment programs, and then examine two of the best-known early identification programs in the light of this need.

Early identification programs may choose between two theoretically distinct methods of identifying predelinquents. Are predelinquents youngsters already in the early stages of a delinquent way of life, or youngsters who have been exposed to circumstances known to cause delinquency? The Cambridge-Somerville Youth Study emphasized the first approach to prediction.[1] "Predelinquents" were nominated by teachers and policemen. The expectation of adolescent delinquency was primarily an extrapolation from quasi-delinquent behavior during preadolescence. Thus, the three raters on the Cambridge-Somerville research team predicted that antisocial tendencies would persist and develop further—unless checked by outside intervention. Early identification in this extrapolative sense is a far cry from identifying potential delinquents according to a theory of delinquency which holds that youngsters exposed to certain sociocultural conditions will become delinquent. Yet the latter is also called "early identification." For example, Sheldon and Eleanor Glueck claim to be able to predict delinquency on the basis of factors distinct from the child's early behavior:

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[1] Edwin Powers and Helen Witmer, *An Experiment in the Prevention of Delinquency: The Cambridge-Somerville Youth Study* (New York: Columbia University Press, 1951), pp. 29–36.

(1) affection of mother for the boy; (2) affection of father for the boy; (3) discipline of boy by father; (4) supervision of boy by mother; and (5) family cohesiveness.[2] The New York City Youth Board is attempting to test this claim by applying the Glueck prediction table to a sample of 223 boys who in 1952 entered the first grade of two New York City schools in a high delinquency neighborhood. Note that the Cambridge-Somerville approach to prediction is far less ambitious than the Youth Board–Glueck approach. One can extrapolate without pretending to know anything about causes. On the other hand, one presumably ought to know a great deal about the causes of delinquency if one hopes to make accurate predictions on the basis of the sociocultural circumstances to which the child is exposed.

This distinction between an extrapolative prediction and a circumstantial prediction, though clear in theory, is often obscured in practice. Diagnostic interviews or self-rating scales (like the Minnesota Multiphasic Inventory) combine the youngster's reports about his own antisocial behavior and/or attitudes with his reports about his family and neighborhood environment. Thus, in many attempts at early identification, the basis for the prediction of future delinquency is not clear.[3] Of course, it can be contended that a better prediction can be made if it is based *both* on the child's early behavior and on his exposure to known deleterious influences. Possibly so. However, such predictions emerge like sausages from a sausage machine—without real insight into *why* they are correct. The drawback of predictions made without theory becomes all too evident when treatment is attempted. Since the prediction is mechanical and does not imply an understanding of the causes of delinquency, it provides no guidance for treatment. "Treatment" becomes an umbrella word meaning all things to all men. A therapeutic program based on family casework is not the same thing as one based on individual psychotherapy, the improvement of reading skills, participation in organized sports, or vocational counseling.

Predictions made without a theory of delinquency causation can be matched with a treatment program that is similarly eclectic. Sometimes it is very difficult indeed to find out what "intensive treatment" consists of. The therapist may contend that each case is unique and that treatment is tailored to the individual case. One might well be suspicious of such vagueness. Vagueness can conceal two kinds of ignorance: ignorance as to what is causing the antisocial behavior and ignorance of the best strategy of intervention. In any case, "individual treatment" programs and programs claiming to "co-ordinate" community resources are in practice not genuinely eclectic. They implicitly answer the question, "What kind of treatment?" by selecting resources ideologically congenial to the agency. For example, the same predelinquent child may be treated through casework techniques if he comes to the attention of one therapist and through group work techniques if he comes to the attention of another. Presumably the type of treatment selected should be governed by the etiological factor involved in the youngster's predelinquency. The type of treatment selected by practitioners of "individual treatment" may be more closely related to the therapist's preconceptions than to the child's problems. This is said, not to condemn efforts to treat predelinquency, but to point out that in the present state of knowledge the frequently invoked analogy between medical practice and de-

[2] Sheldon and Eleanor Glueck, *Unraveling Juvenile Delinquency* (New York: The Commonwealth Fund, 1950); Sheldon and Eleanor Glueck, *Predicting Delinquency and Crime* (Cambridge, Mass.: Harvard University Press, 1959); Eleanor T. Glueck, "Efforts To Identify Delinquents," *Federal Probation*, Vol. 24, No. 2 (June 1960), pp. 49–56.

[3] D. H. Stott, "The Prediction of Delinquency from Non-delinquent Behavior," *British Journal of Delinquency*, Vol. 10, No. 3 (January 1960), pp. 195–210.

linquency control is misleading. Whereas medical practice aims at precise diagnosis and specific treatment, early identification and intensive treatment of delinquency usually address themselves to an unknown problem with an unproved technique. Is it any wonder that treatment programs that have been rigorously evaluated reveal disappointingly small effects? For instance, the Cambridge-Somerville Youth Study offers little support to proponents of "early identification and intensive treatment" as an approach to delinquency control. Whereas 41 percent of the 253 boys in the treatment group subsequently were convicted of at least one major crime in a state or federal court, 37 percent of the 253 boys in the control group were so convicted. Considering (a) that treatment began by age 10 for 121 boys and by age 13 for the remaining 132, and (b) that treatment lasted for four years or more for 171 boys, *more* criminality in the treatment group is rather surprising. The McCords point out that only twelve of the 253 boys had intensive therapy (according to their quite reasonable criteria of "intensive"), and they suggest that for this reason intensive treatment was not really tested. Perhaps so. On the other hand, it seems doubtful that a probation or parole system in the United States gives as intense supervision as was given routinely in the course of the Cambridge-Somerville Youth Study. The case loads of Cambridge-Somerville workers were 34 youngsters per counselor at the beginning of the study and even fewer when the boys grew older.[4]

TACIT ASSUMPTIONS

Let us examine the logic of early identification and intensive treatment from another angle. Presumably the rationale of early identification is to economize treatment efforts. Otherwise, society would expose all youth to whatever resources are available for delinquency control. But in order for economy to be achieved, the predictions must be accurate. If delinquency occurs in too many cases where nondelinquency was predicted or *fails* to occur in too many cases where it *was* predicted, economy may not be realized. Once it has been established that the predictions are sufficiently accurate, much greater intensity of treatment efforts is possible because youngsters not in danger of becoming delinquent can be ignored.

It is usually tacitly assumed by the proponents of "intensive treatment" that treatment is more effective the more intensive it is. This is not necessarily so. Consider that the focusing of treatment efforts on youngsters most likely to become delinquent necessarily involves special handling for them. It is extremely difficult for a focused treatment program to avoid stigmatizing the recipients of the "benefits" of the program. Early identification does not necessarily imply early stigmatization, but early *discriminatory* treatment seems to. Thus, it is conceivable that a boomerang effect will occur, and that greater intensity of exposure to treatment will be *less* effective than less intense but less discriminatory exposure. Suppose, for instance, that a community has an organized recreational program for *all* children up to the age of 16. Someone convinces the city fathers that organized recreation can prevent delinquency, so the program is changed to focus on identified predelinquents. Instead of 1,000 boys using the facilities occasionally, 200 boys use them frequently. Before leaping to the conclusion that these 200 boys are less likely to become delinquent, let us consider what the impact of their segregation is on "predelinquents." We know from experience with ability groupings in the schools that the evaluations of the adult world cannot be concealed from youngsters. Just as the children in the "dumb" classes know that they are not in the "smart" classes, these 200 boys are unlikely to think of themselves

[4] *See* Powers and Witmer, *op. cit.*, pp. 85, 88; William and Joan McCord, *Origins of Crime: A New Evaluation of the Cambridge-Somerville Youth Study* (New York: Columbia University Press, 1959), pp. 20, 26, 29, 38–39.

as the pride of the community. It is possible that less intensive recreational participation would have been more effective in arresting their delinquent tendencies than the more intensive—and incidentally more stigmatizing—exposure.[5]

There is at least one other hidden assumption of early identification; it bears on the possibility of accuracy of prediction. In order to predict accurately the occurrence of adolescent delinquency from either preadolescent behavior or preadolescent circumstances, the forecaster must assume that no really crucial etiological factors make their initial appearance *after* the original predictions have been made. For instance, in the New York City Youth Board project, the ratings of the family backgrounds of the 223 boys were made when they were 6 years old. If family relations are the major factor in delinquency, and if family relations change appreciably in the course of the study, the predictions ought not to be very accurate.[6]

But let us make a further supposition. If the studies which sociologists have been making of adolescent street corner groups mean anything at all, they mean that youngsters who join such groups are far more likely to commit delinquent acts than youngsters who do not join such groups. Since delinquent groups rarely recruit members younger than 10, why should we expect ratings of family background made when the boys were 6 to predict delinquency at the age of 15? Clearly, this expectation rests on the assumption that early childhood experiences are so important that they establish a differential vulnerability for all subsequent experiences. This assumption may or may not be correct—Freudian psychiatrists tend to subscribe to it; sociologists, on the other hand, tend to believe that socialization continues throughout life and that the course of a child's life can be radically changed by group experiences subsequent to the age of 6.

The Cambridge-Somerville Youth Study and the New York City Youth Board Prediction Study did not assess the effect of neighborhood, ethnic background, or socioeconomic status on the accuracy of their predictions. As a result, they missed an opportunity to clarify the conditions under which predisposing psychological factors eventuate in delinquency. I propose to examine both studies in the light of these omissions in order to demonstrate that explicit consideration of the social context is necessary for further progress in delinquency prediction.

THE CAMBRIDGE-SOMERVILLE YOUTH STUDY

Table 1 shows a positive relationship between the original predictions of delinquency made in 1937–38 and the judgments of outcomes made in 1947–48.[7] Insofar as errors of prediction occurred, they were mainly overpredictions of delinquency. That is, of the 138 boys for whom delinquency was predicted, 53 turned into "good" boys (38 percent). On the other

[5] Proponents of early identification and intensive treatment might argue that stigmatization occurs but that it is helpful in preventing delinquency (by nipping the deviant tendency in the bud). Law enforcement officials sometimes use this argument, but they usually talk in terms of "punishment" rather than "treatment." Social workers and psychiatrists seem unwilling to face the logical possibility that well-intentioned "treatment" can do more harm than good.

[6] Prof. Isidor Chein of New York University suggested that the Youth Board rate the family situations of the 223 boys again several years after the original ratings were made. How well would the two sets of ratings correlate with one another? If the later ratings are less closely related to outcome than the earlier ratings, this would tend to support the Glueck hypothesis that the early family situation is the major factor in delinquency. If the later ratings are more closely related to outcome than the earlier ratings, this would suggest that the contemporary situation—familial and extrafamilial—is more important in the genesis of delinquency than the Gluecks think. The Youth Board has Professor Chein's intriguing suggestion under consideration.

[7] Powers and Witmer, *op. cit.*, pp. 278, 280, is the source of the data presented in Table 1.

TABLE 1. COMPARISON OF ORIGINAL PREDICTIONS AND FINAL JUDGMENTS
100 TREATMENT BOYS, 100 CONTROL BOYS
(Cambridge-Somerville Study)

Original Predictions, 1937–38	*Final Judgments, 1947–48*			
	Total	Moderately or severely delinquent	Occasionally or seldom delinquent	Least delinquent
Probably delinquent	138	50	35	53•
Undecided	12	1•	3•	8
Probably nondelinquent	50	4•	5•	41
Total	200	55	43	102

• Errors of prediction.

N.B.: For the purposes of assessing errors of prediction (a) the "least delinquent" outcome was considered to be *nondelinquent* and other outcomes to be *delinquent,* and ((b) the "probably delinquent" prediction was considered to be a prediction of *delinquency* and the others to be predictions of *nondelinquency.*

hand, only 13 of the 62 for whom nondelinquency was predicted became delinquent (21 percent). These results are certainly interesting. Predictions that "bad" boys would continue into adolescence the antisocial behavior of preadolescence and that "good" preadolescents would *not* turn into delinquents were in general correct. Nevertheless, 66 out of the 200 predictions were incorrect (33 percent).

Suppose these 200 cases could be partitioned into meaningful subsamples; it might then be possible to find out why so many errors of prediction occurred and, hopefully, the conditions making for more accurate predictions. For example, various ethnic groups are represented in the study population: "Italian," "Other Latin," "Negro," "Eastern European," "Western European," and "Native American." [8] If predictions were more accurate for Italian boys than, say, for native American boys, this might throw light on the relationship between cultural values and delinquency.[9] Similarly, several socioeconomic levels and types of neighborhoods were represented in the study. Was prediction more successful for middle-class or lower-class boys (as indexed by fathers' occupations); for slum-dwelling youngsters or for boys who lived in better neighborhoods? These questions were not asked—therefore they were not answered. To answer such questions, it would be necessary to reanalyze the data in the Cambridge-Somerville Youth Study files.

In order to demonstrate what could be learned from such a reanalysis, a hypothetical tabulation has been constructed (Table 2) such as would emerge from the partition of the Cambridge-Somerville cases into subsamples of neighborhoods. Table 2 is not entirely speculation. It is based partly on known characteristics of the study population and partly on hypotheses which

[8] The ethnic data relating to the study population do not appear in *Origins of Crime* but are found in a second volume which explored the causes of alcoholism rather than crime. For information on ethnic groupings, *see* William and Joan McCord, *Origins of Alcoholism* (Stanford, Calif.: Stanford University Press, 1960), p. 38.

[9] *See* Jackson Toby, "Hoodlum or Business Man: An American Dilemma," in Marshall Sklare, ed., *The Jews* (Glencoe, Ill.: The Free Press, 1958), pp. 542–550, for a discussion of the relationship between ethnic background and delinquency.

TABLE 2. HYPOTHETICAL PARTITION OF CAMBRIDGE-SOMERVILLE YOUTH STUDY CASES BY NEIGHBORHOOD

Predictions	*Outcomes*					
	Better Neighborhoods			Slum Neighborhoods		
	Delinquent	Nondelinquent	Total	Delinquent	Nondelinquent	Total
Delinquent	17	20*	37	54	43*	97
Nondelinquent	5*	25	30	6*	30	36
Total	22	45	67	60	73	133

* Errors of prediction.

can be tested by unpublished data in the study files. Specific numbers have been used in the table in order to be as concrete as possible about the hypotheses under consideration. Lest readers be misled, however, as to where facts end and conjecture begins, the factual and the conjectural inferences reflected in Table 2 are as follows:

Facts

1. Two-thirds of the boys in the study came from slum neighborhoods, and only one-third from better neighborhoods. According to the reanalysis of the Cambridge-Somerville data by the McCords as presented in *Origins of Crime,* 33 percent of the treatment group and 38 percent of the control group came from neighborhoods rated "good" or "fair." The remainder came from neighborhoods rated "poor" or "worst." [10]

2. Delinquent *outcomes* occurred more frequently in the slum neighborhoods than in the better neighborhoods. Thus 45 percent of the boys from slum neighborhoods became delinquent as compared with 33 percent of boys from better neighborhoods.[11]

Hypotheses

1. The published reports on the study do not give any indication as to whether the *predictions* of delinquency (as contrasted with *outcomes* of delinquency) varied by neighborhood. *The hypothesis here is that a reanalysis of the Cambridge-Somerville data would reveal that a greater proportion of boys from slum neighborhoods than from better neighborhoods were identified by the raters as "probably delinquent."* We start with 200 boys (from Table 1) and the known fact that about two-thirds of the total study population came from slums and one-third from better neighborhoods. Let us suppose, then, that out of the two-thirds (or 133) who came from slum neighborhoods, 97 (73 percent) were predicted delinquent, while of the one-third (or 67) from better neighborhoods, only 37 (55 percent) were predicted delinquent. Table 2 gives us a statistical picture of this supposition

[10] *Origins of Crime, op. cit.,* p. 70. Here is how the McCords describe the latter: " 'Poor' areas were actual slums, characterized by material poverty, the existence of gangs, and a distinct lack of community organizations. The 'worst' areas lacked neighborhood pride or organization, were socially heterogeneous, dominated by gangs, and plagued by unemployment and bitterness."

[11] Of the 174 treatment and control boys from "good" and "fair" neighborhoods, 57 became delinquent (33 percent). Of the 309 treatment and control boys from "poor" and "worst" neighborhoods, 139 became delinquent (45 percent). *Ibid.,* pp. 71, 204.

that there was a greater tendency to *predict* delinquency for a slum than for a nonslum neighborhood.

2. The published reports on the study do not give any indication as to whether the relationship between predictions and actual outcomes varied by neighborhood. *The hypothesis here is that a reanalysis of the data would reveal that neighborhood of residence has more relevance to the relationship between predictions of delinquency and actual outcomes than to the relationship between predictions of nondelinquency and actual outcomes.* Specifically:

a. Predictions of *delinquency* are more likely to be correct in the slum neighborhoods than in the better neighborhoods. This hypothesis is expressed quantitatively in Table 2 by having 54 of the 97 boys in the slum neighborhoods for whom delinquency was predicted become delinquent (56 percent) as against 17 of the 37 boys in the better neighborhoods (46 percent).

b. Predictions of *nondelinquency* are no more likely to be correct in one type of neighborhood than another. This hypothesis is expressed quantitatively in Table 2 by having 6 out of 36 boys in the slum neighborhoods (17 percent) and 5 out of 30 in the better neighborhoods (17 percent) turn out delinquent despite predictions to the contrary.

It is possible to be fairly confident in the correctness of Hypothesis 2 (a). Another way of stating it would be to say that "bad" preadolescents are *more* likely to persist in delinquency if they live in slum neighborhoods rather than in better neighborhoods. This rests on a widely accepted generalization about the patterning of delinquency in American cities. As Thrasher, Shaw and McKay, and Cloward and Ohlin[12] have demonstrated, delinquency in a slum neighborhood is qualitatively as well as quantitively different from delinquency in a middle-class suburb. Delinquency in a slum is an adolescent tradition; it is more often an expression of allegiance to a delinquent gang than of pathological personality needs.

Hypothesis 2 (b) is more open to question. Restated as above, it is, namely, that the *same* percentage of "good" preadolescents will become delinquent in slum and better neighborhoods. If confirmed, this suggests that the delinquent peer group has a quite different impact on troublesome preadolescents and on conforming preadolescents, *i.e.*, those with nondelinquent self-conceptions.[13] On the other hand, if it should turn out that the percent of error in the prediction of nondelinquency in slum neighborhoods is greater than in better neighborhoods, this suggests that the delinquent peer group influences the "normal" preadolescent and not only the delinquency-prone youngster.

Before leaving the Cambridge-Somerville Youth Study, let me call attention to the relevance of social context for the evaluation of *treatment effects.* After all, the study was an experiment in treatment, not an academic exercise in prediction. True, the published reports failed to demonstrate that the treatment group as a whole was less criminal than the control group. The published reports did not, however, consider whether some ethnic or socioeconomic subsamples fared especially well or poorly. Table 3 illustrates the method of examining the differential effects of treatment in various social contexts by juxtaposing conviction rates for treatment and control boys in four types of neighborhood.[14] (Table 3 consists of actual data from the study; it is not hypothetical.) Note that the relation-

[12] Frederick M. Thrasher, *The Gang* (Chicago: University of Chicago Press, 1927); Clifford R. Shaw and Henry D. McKay, *Juvenile Delinquency and Urban Areas* (Chicago: University of Chicago Press, 1942); Richard A. Cloward and Lloyd E. Ohlin, *Delinquency and Opportunity* (Glencoe, Ill.: The Free Press, 1960).

[13] Walter C. Reckless, Simon Dinitz, and Ellen Murray, "Self-Concept as an Insulator Against Delinquency," *American Sociological Review,* Vol. 21, No. 6 (December 1956), pp. 744–747.

[14] William and Joan McCord, *Origins of Crime, op. cit.,* pp. 71, 204.

TABLE 3. DELINQUENCY AMONG TREATMENT BOYS AND AMONG CONTROL BOYS IN THE CAMBRIDGE-SOMERVILLE YOUTH STUDY, BY TYPE OF NEIGHBORHOOD

Type of Neighborhood	% of Convictions in Treatment Group (N=233)	% of Convictions in Control Group (N=250)
Good	38	26
Fair	37	33
Poor	40	44
Worst	46	49

ship between criminality and neighborhood is much stronger for the control group than for the treatment group, possibly because of sampling peculiarities. Suppose, however, that the more delinquent behavior of treatment boys in better neighborhoods (as compared with control boys) was not a peculiarity of sampling. How could it be explained? One possibility is boomerang effects. Maybe treatment was more stigmatizing in better neighborhoods where the visits of workers from the study were more conspicuous. Or perhaps the early identification procedure brought different types of youngsters to the attention of the study, depending on the type of neighborhood in which they lived. Possibly preadolescent misbehavior serious enough to identify a boy as a potential delinquent is a sign of psychopathology *if it occurs in a middle-class community*. Since psychopathology is notoriously difficult to cure, and since the study was not specifically oriented to psychiatric therapy, this might account for the lack of success of the study workers in the better neighborhoods.

NEW YORK CITY YOUTH BOARD PREDICTION STUDY

The New York City Youth Board Prediction Study differed from the Cambridge-Somerville Youth Study in important respects. In the first place, all the boys for whom delinquency predictions were made came from slum neighborhoods. Second, the predictions were based on home visits by social workers when the youngsters entered the first grade. They gave negligible weight to a factor particularly stressed in the Cambridge-Somerville Youth Study, the boy's own behavior. The critical question, of course, is: By what mechanism do "bad" family situations lead to delinquency in a slum neighborhood? Consider two quite different mechanisms by which a bad family situation might lead to delinquency:

1. Parental rejection and neglect damage the personality of the developing child. Delinquent behavior results from inadequate or pathological socialization.

2. Parental inadequacy and neglect, though not productive of psychopathology, tend to orient the boy toward his agemates in the neighborhood instead of toward his family. If the peer group is delinquent, his need for acceptance by the gang necessitates participation in delinquent activities.

The Youth Board researchers do not make entirely clear which of these two mechanisms they think is at work. It is likely, of course, that both mechanisms are involved, mutually reinforcing each other. Still, it is necessary to evaluate the relative weight of the two. If mechanism (1) predominates, offenses ought to be the impulsive acts of a psychopathic or neurotic child: fire-setting, purposeless violence, stealing of unneeded and unwanted objects. If mechanism (2) predominates, offenses ought to be explainable in terms of group requirements: to show "heart" or to obtain enough money to live up to gang standards of expenditure for clothes, cigarettes, liquor. Furthermore, if mechanism (1) predominates, prediction ought to be equally successful in slum and better neighborhoods, whereas if mechanism (2) predominates, prediction ought to be more successful in slum neighborhoods. (Unfortunately, the Youth Board study was not designed to enable such interneighborhood comparisons to be made.)

It is suggestive that the Youth Board used two of the Gluecks' five factors (mother's supervision and cohesiveness of the family)

TABLE 4. A COMPARISON AMONG THE YOUTH BOARD TWO OR THREE FACTOR TABLE, THE GLUECK FIVE FACTOR TABLE, AND A SINGLE FACTOR (PUBLIC ASSISTANCE) IN PREDICTING DELINQUENCY

1952 Predictions Based on:		Outcomes, 7 Years Later	
	Total	Delinquent	Nondelinquent
Two or Three Factors			
Probably delinquent	37	13	24•
Probably nondelinquent	186	8•	178
Total	223	21	202
Five Factors			
Probably delinquent	67	17	50•
Probably nondelinquent	156	4•	152
Total	223	21	202
Single Factor: Economic Status of Family When Boy Entered School in 1952			
Public assistance	52	13	39•
No public assistance	171	8•	163
Total	223	21	202

• Errors of prediction.

supplemented by a third factor (father's discipline), thereby reducing the incorrect predictions in Table 4 from 54 to 32.[15] From this it might be inferred that the eliminated factors (affection of mother for boy and affection of father for boy) ". . . are not potent in the etiology of delinquency." Eleanor Glueck assures her readers that "this is not the case." [16] She explains the greater accuracy of the two- or three-factor scale as compared with the original five-factor scale as due to inconsistency of ratings of parental affection by social workers of different intellectual persuasions and to the difficulty of making ratings for families where the father has long been out of the home. Moreover, she shows that the intercorrelation among the five factors is considerable. For example, in the original Boston study the correlation between total scores based on five factors and the total scores based on two factors is .932.[17] Thus, she infers that lack of parental affection is very important indeed in the etiology of delinquency but that affection is implicitly measured along with the two or three factors in the Youth Board adaptation of the

[15] Mrs. Maude Craig, research director of the Youth Board, graciously provided unpublished data on the economic status and the ethnic backgrounds of the 223 boys in the study.

[16] Eleanor T. Glueck, *op. cit.*, pp. 55–56.

[17] *Ibid.*, p. 56. A statistician usually interprets such high covariance (or intercorrelation) as indicating that he has measured the same variable with items of apparently different content. This is often cause for jubilation because it makes possible the construction of a unidimensional scale. *See* the contributions by Louis Guttman and Paul F. Lazarsfeld in Samuel A. Stouffer *et al., Measurement and Prediction* (Princeton, N. J.: Princeton University Press, 1949). As Mrs. Glueck makes clear, however, she does not interpret the intercorrelations among her scale items in this way. She maintains that there are five independently important contributing factors but, apparently because of the difficulties of measuring them in pure form, the items intercorrelate.

TABLE 5. DIFFERENTIAL IMPACT OF A "BAD" FAMILY SITUATION ON ECONOMICALLY DEPENDENT AND ON SELF-SUFFICIENT WHITE, NEGRO, AND PUERTO RICAN FAMILIES

Ethnic Background	1952 Predictions Two and Three Factor Table	1959 Outcomes					
		For 1952 Public Assistance Families			For 1952 Self-sufficient Families		
		Delinquent	Nondelinquent	Total	Delinquent	Nondelinquent	Total
White	Probably delinquent	1	2*	3	0	1*	1
	Probably nondelinquent	0*	0	0	0*	49	49
	Total	1	2	3	0	50	50
Negro	Probably delinquent	4	9*	13	4	11*	15
	Probably nondelinquent	4*	19	23	3*	77	80
	Total	8	28	36	7	88	95
Puerto Rican	Probably delinquent	3	1*	4	1	0*	1
	Probably nondelinquent	1*	8	9	0*	25	25
	Total	4	9	13	1	25	26
All	Probably delinquent	8	12*	20	5	12*	17
	Probably nondelinquent	5*	27	32	3*	151	154
	Total	52	39	52	8	163	171

* Errors of prediction.

Glueck scale. Perhaps so. On the other hand, a quite different interpretation of the data is possible. Maybe the crucial variable in this high-delinquency neighborhood is parental *control* over their children. Maybe the short scale predicts more accurately in the Youth Board study because family cohesiveness, mother's supervision, and father's discipline are more closely related to *control* than is parental affection.

Note in Table 4 that the one-factor prediction table (based on whether the family of the boy was receiving welfare assistance at the time he entered school) predicted delinquency over a seven-year period about as well as the original five-factor scale, but less well than the revised two- and three-factor scale. This suggests that the mechanisms whereby a "bad" family situation predisposes to delinquency involve a complex combination of socioeconomic and psychological deprivation, not psychological deprivation alone. In an effort to throw further light on these complexities, Table 5 shows the relationship between the two- and three-factor prediction table and delinquency for three ethnic groups and two economic statuses. There are a number of interesting inferences to be drawn from Table 5.

a. Prediction of delinquency and nondelinquency is *least* successful for Negroes (as contrasted with whites and Puerto Ricans). Among the public assistance Negro families, 13 out of 36 predictions were incorrect (36 percent), whereas 14 out of 95 predictions for self-sufficient Negro families were incorrect (15 percent). By

contrast with Negro families, 2 out of 13 predictions were incorrect for public assistance Puerto Rican families (15 percent) and none for self-sufficient Puerto Rican families. (There were so few white families on public assistance that it would be hazardous to make inferences from the incorrect predictions made in that category—2 out of 3.)

b. The errors in predictions are much *greater* for public assistance families than for self-sufficient families (33 percent compared with 9 percent). This is partly a function of the greater likelihood for public assistance families to be predicted "delinquent" (38 percent compared with 10 percent); and since delinquency tends to be overpredicted—as in the Cambridge-Somerville study—the predictions made about the public assistance families have a built-in bias in favor of incorrect predictions. However, this bias does not account completely for the greater errors of prediction for public assistance families. Eight of the 20 public assistance families whose children were given a better than even chance of becoming delinquent actually became so (40 percent); this contrasts with 5 of the 17 self-sufficient families (29 percent). Similarly, there were more errors of prediction among public assistance families given *less* than an even chance of producing a delinquent than among self-sufficient families in the probably nondelinquent category.

Interpretation. The varying accuracy of predictions depending on the social context sets a problem for further research. While it seems to be possible to identify families whose children have a higher probability of becoming delinquent than the children of a random sample of families, the precise explanation of this correct identification has yet to be found. Under what social conditions will pathologies of family life eventuate in delinquency?

CONCLUSION

The identification of potential delinquents is possible in a crude way right now. On the other hand, *accurate* prediction of delinquency and nondelinquency depends on a scientific understanding of the causes of various types of delinquency. Until such etiological questions as the relationship between family pathology and peer group influences are clarified, therapeutic programs will continue to grope. Even if etiological problems are clarified, however, the strategy of intervention is not immediately apparent. Regardless of the client problem that is being addressed through a special treatment program for predelinquents, that program must avoid the boomerang effects of early stigmatization. Perhaps boomerang effects are the major reason why not a single validated example exists of successful early identification and intensive-treatment programs. In short, one may conclude that much can be learned about causes of delinquency from attempts at early identification, but that such programs are not now a practical approach to delinquency control.

Let us add a few words of a more hopeful kind. Efforts to control delinquency do not have to depend on early identification. The delinquency control programs of Mobilization for Youth on the Lower East Side of New York City and of the Chicago Boys' Clubs in three neighborhoods of Chicago provide services which do not require identification of predelinquents. It remains to be seen whether such programs are more successful than those which are predicated on early identification. They start out, however, with two advantages: (1) they are not limited to youngsters whose family situations or personal behavior foreshadow delinquent development; (2) they do not have to cope with the program-neutralizing effects of stigmatization.

BY HERMAN D. STEIN

Administrative Implications of Bureaucratic Theory

THE GENERAL DEVELOPMENT of bureaucratic theory, stemming from Max Weber's original formulations, has received impetus in the past decade, and the understanding of organizational behavior has been greatly enhanced as a result. The inferences to be drawn by administrators and others in a position to influence organizational development have, by comparison, received little attention. This discussion is, therefore, related to specifying a tentative series of such inferences rather than to an attempt to examine or extend the area of theory. Two themes of existing theory are considered for these purposes: strengths and strains related to structural attributes of bureaucracy, and the relationship between formal and informal organization.

STRENGTHS OF BUREAUCRATIC STRUCTURE

In the social scientific sense, the term "bureaucratic structure" has no necessarily invidious connotation. It refers, rather, to a form of rational organization conceived thus far to be indispensable to the mass production of goods and services. The extension of bureaucracy has been a concomitant of technological development in all countries where such development has taken place.[1] Government bureaus, industrial organizations, the armed services, trade unions, schools, and hospitals have all reflected this trend in the United States; and, as has been amply demonstrated, social agencies, whether public or voluntary, are not strangers to this development.[2]

Bureaucracy, as a rational form of organization, depends for its most effective functioning upon planned co-ordination of its parts, clarity in its policies, specificity in the roles of all who are part of the organizational system, and impersonality in its discharge of functions. When referring to *inherent strengths* of bureaucratic structure, one is not suggesting that every organization so characterized includes these virtues; rather that the central tendencies of bureaucratic structure, when the most rational principles are applied, are consistent with these attributes. Such "strengths" may be characterized as follows:

Economy and efficiency. Contributed to by rational division of labor and pooling of *expertise.*

Stability and permanence. A bureaucracy is not easily shaken by the loss of one person, since the office to be filled tends to be more important than the particular individual who occupies it. Such structures maintain a high investment in stability and permanence.[3]

Role security. Occupational roles tend to be highly specific. What is expected on the job is relatively clear. Job descriptions and formal communication processes tend to be defined.

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[1] Peter M. Blau, *Bureaucracy in Modern Society* (New York: Random House, 1956).

[2] Harold L. Wilensky and Charles N. Lebeaux, *Industrialization and Social Welfare* (New York: Russell Sage Foundation, 1955).

[3] A maxim in administrative circles is that "the easiest way to start a permanent organization is to start a temporary one."

Relative job security. Bureaucratic structures have an investment in retaining personnel in the interests of stability, and thus tend to promote not only fringe benefits but in-service training programs, retirement programs, and so on.

Impersonality of policies. Bureaucracies tend to minimize subjective elements in determination of policies and to maximize the establishment of objective and impersonal criteria, with the following results:

1. For the consumer of the organization's goods or services, this can have the effect of democratization through uniform applicability of criteria, as long as the consumer meets established criteria. Whether it is having the amount of money to purchase the goods or services, or the requisite financial need to obtain public assistance, the tendency is to minimize discretion based on subjective considerations. (The owner of a small neighborhood grocery store may provide credit to his customers based on his personal knowledge and opinion of them. In a large urban supermarket there would either be "no credit" for anyone, or it would be established on the basis of uniform procedures.)

2. For the personnel of the organization impersonality of policies tends to make for relatively objective criteria for evaluation, promotions, sick leave, vacations, and so on. Aside from inducing expectations that can be realized and providing clarity for job conditions, the application of the principle of maximum impersonality tends also to reduce interpersonal competition for advancement within an organization. The competition may be related to examinations or to the achievement of certain experience or skills deemed necessary for promotion and not, for example, to competition between two or more people for the favor of a superior.

INHERENT STRAINS

While bureaucracy tends to bolster such strengths, its structure also contains inherent strains. By strains, in this sense, are meant tendencies likely to arise unless specifically planned for and prevented. These strains may be viewed in four areas: personnel, the consumer, management, and the community.

Personnel. 1. Ritualism.[4] This is the condition where means become ends. The very fact that roles are defined, that the job tends to be precisely described, provides a congenial situation for the employee who feels constrained only to do his particular job "right" without reference to its meaning for the total organization, and not to exercise judgment or deviate from established routine. A "ritualist" in a mail-order house whose job it is to seal up envelopes on the assembly may continue to do so even if the envelopes she is sealing happen not to have anything in them. A "ritualist" in a hospital will wake a patient soundly asleep in order to give him a sleeping pill because that is the routine practice for that precise hour.

2. Mediocrity and overconformity. These are the tendencies which have recently been emphasized on the public rostrum, in the press, and in books such as *The Organization Man.*[5] "Not getting into trouble" and "playing it safe" tend to be requisites for maintenance of job tenure and among the criteria for eventual promotion when length of service is a prime factor in this regard. The system may both attract conformists and remove the potential for constructive nonconformity by adhering rigidly to prescribed policies and procedures. In the long run the diffusion of mediocrity serves to militate against the most important *raison d'être* of bureaucracy itself, namely, economy and efficiency. Another aspect of this condition is lack of stimulus for imagination or creativity. The absence of a demand for one's

[4] Robert Merton, "Bureaucratic Structure and Personality," in Merton, ed., *Reader in Bureaucracy* (Glencoe, Ill.: The Free Press, 1952).

[5] William Whyte, *The Organization Man* (New York: Doubleday & Co., 1957).

thinking and evaluation and the adherence, rather, to making sure that the defined job is done can have the effect of stifling potential imaginative contributions which could add to the effectiveness of the organization.

The consumer of goods or services. The very impersonality of criteria when applied to the consumer can make it difficult for the individual to be properly served and leave the organization incapable of meeting crisis situations or emergencies. When the consumer confronts an organization in this context he has the sense of dealing with a system, not with a person. It is at this point that the reproach of "red tape" is most frequently applied. A customer who is making a fast purchase when a store is closing and is told that he cannot complete the purchase because the store closed at that very moment is bound to be frustrated. The employee in such a situation is not concerned with the customer but with conforming to the prescription of his job, and when the bell sounds slams the register shut. The parent in distress after his child's accident is depressed by the impersonality of eligibility criteria when he is compelled to see that the proper forms are filled out at the hospital to assure his financial condition before he can return to his child.

Management. Lack of adaptability to change can be a consequence of the investment in the organization's stability and permanence. Ritualistic, unimaginative, and overly formalized behavior may become norms of management, as well as of other personnel.

Community. Bureaucracies tend to be self-protective, and it is difficult for the outside community, except in cases of violation of law or other crises, to gain access to the organization or affect its structure (more so, of course, in voluntary than in public agencies). While the cohesiveness of the organization can be an asset, it also promotes unwillingness to expose its internal system to public scrutiny because of the danger of upsetting the authority balance within the organization, or to reveal practices deemed necessary for internal stability but not easily reconciled with public or official goals of the organization. This condition of protective shielding from the public can become particularly important in social agencies, which in the last analysis are accountable to the public, whether or not the agencies are supported by tax funds.

ADMINISTRATIVE IMPLICATIONS

One general principle should govern an approach to preventing, mitigating, or compensating for strains arising from bureaucratic organization: that preventive countermeasures should themselves be consistent with bureaucracy. That is, such means should themselves be rational and official, maintain specificity of roles and clear procedures, maximize impartiality, and the like. In other words, a bureaucratic organization would not be consistent if, in attempting to lessen overconformity, it should say to personnel, "Just use your own judgment," but may more consistently say to a specific department or level of personnel, "In these and these situations discretion may be exercised up to this point, utilizing the following criteria as guides."

Further, it is obvious that no organization, however ingeniously run, is without its problems while it lives, grows, and changes. It is with the capacity of an organization to strengthen itself, to detect and deal with its problems—not to remove all problems for all time—that any consideration of administrative practice must be concerned.

Following are observations bearing on the reduction or prevention of organizational strains. While they are grouped in relation to implications for personnel, consumer (of service), management, and community, it should be clear that measures taken in relation to any one of these potential strains may affect more than one of these components of the agency network.

PERSONNEL

Prevention of ritualism. Ritualism develops when personnel are either permitted or encouraged to wear "organizational blinkers" so that they see neither to left nor right but keep their eye on the immediate job for which they have been hired. It can pervade not only personnel who do routine mechanical operations, but professional and managerial personnel as well. Ritual behavior is unconcerned with the larger organizational purposes, and can lead to the aggrandizement of one's own job or one's own department at the expense of others or at the risk of disturbing the organization's rational balance and coordination of functions.

The prevention of ritualism is, therefore, in the direction of policies and procedures that make it possible for personnel to be oriented to the central objectives of the organization, to see how their functions relate to those of others, and to be concerned about such interrelationships. Some of the simple techniques in this area are well known, for example, the orientation of new staff by actually taking them around an office or plant, general meetings of the entire staff, annual reports, interdepartmental meetings, and so forth. An appropriate program for a given organization will depend partly on its complexity and partly on the precise character of its organizational cast, as well as its function and objective. As will be noted below in another connection, the supervisory chain of command is crucial to the mitigation of this as well as other strains, if nonritualistic behavior is regarded as a positive criterion of performance and evaluated accordingly through the entire organization.

Programs may vary for different echelons of the organization, and when carried out "nonritualistically" may have the effect of reducing the tendency to encapsulate one's own task as if it were the only important one in the organization without reference to its meaning for others, and may encourage flexibility and judgment when the need arises.

Provision of opportunities for new ideas. The accent on stability and permanence can have the effect of making "not rocking the boat" a central concern. Where this is the prevailing norm, not only will potential ideas in the service of the organizational purposes not be tapped, but their sources will dry up. One is familiar with primitive devices such as the suggestion box, or more recent notions such as "brainstorming" in executive idea sessions, as means for encouraging or stimulating imaginative contributions. Some industrial organizations have attempted to cope with this problem partly by creating "islands of creativity" where scientists and professionals who have achieved superior standing within the organization are permitted a place to work and resources without restriction on what they do, and without having to abide by the normal routines of the organization.

To utilize individual initiative and imagination would seem to require, however, a pervasive, built-in policy through the entire administrative structure, pervading the organization and effectuated through its entire supervisory apparatus. Thus, every supervisor at whatever level would have as part of his obligation the need to inquire as to suggestions or ideas, to evaluate them, and to utilize what is possible, and would *himself* be evaluated partly on his capacity to fulfill this supervisory requirement. The organization itself can thus better harness its potential from personnel, and for those who are able to contribute ideas rewards, whether in economic or other terms, should be forthcoming.

CONSUMER

Prevention of rigidity toward the consumer. Bureaucracy requires policies and regulations, but also ways of individualizing and dealing with the exceptional situation or the emergency. It is possible for

a bureaucracy to develop ways of dealing with the exceptional case in a manner which is consistent with the needs of such a structure. Essential in any method of dealing with the emergency or exceptional case is for the organization to recognize that such cases may arise—situations not anticipated by existing policy. Responsibility for emergencies or special cases should, therefore, be centralized and clarified to avoid the exasperating phenomenon of an organization representative who says, in effect, "I'm sorry I can't deal with that and I don't know who does."

Anticipated emergencies can be met by policies that set the levels of discretion appropriate to different staff. For example, a family agency might be able to permit its workers to grant emergency financial assistance at their discretion up to a certain amount without further check, increase the amount at the discretion of supervisory personnel, and beyond this limit require authorization from the executive. Such policies with regard to limits of discretion are possible when emergencies can be foreseen.

When emergencies or special cases begin to assume recognizable patterns, policies can be developed for such situations and responsibilities allocated for carrying them out, so that the situations themselves no longer assume a special or emergency character.

MANAGEMENT

Adaptability to change. The processes of change in large organizations are still not too well understood, but change does occur and often reveals imagination and creative planning rather than being simply accidental. To develop the actuality of change toward well-understood goals requires, of course, that the function of planning be clearly located within the organization. Unless planning is a conscious activity it will not tend simply to happen. There will be changes, but they will be uncontrolled and at the mercy of external factors rather than self-directed, or planned to meet the influences of external pressures in the environment of the organization.

The centralization of a planning function does not mean, however, that participation in planning and in policy formulation must be restricted to a specific individual or group of individuals. On the contrary, participation in planning can and should be widespread through an organization. In making this point one is not referring to so-called "democratic administration" where everyone in an organization has an equal voice in planning—or where the right, if not the fact, of such "democratic" participation is conceded. In large formal structures democratic administration in this sense is a contradiction in terms and virtually impossible. What is possible, however, is tapping the understanding, ideas, and motivations of people in an organization according to their special competence and interests—that is, through *relevant participation.* One way of making the bureaucratic structure more adaptable to change is to build into the administrative process modes of participation that would elicit the contribution of all those in the organization who have something to contribute out of their legitimate roles, experience, and organizational interests. This can be true whether one is dealing with planning for budget, for locating unseen problems, or for devising new approaches to meet existing conditions.

The concept of relevant participation does not mean having everyone responsible for everything, and certainly is not the same as trying to have participation for its own sake as a morale-builder. Such specious involvement is self-defeating and can only lead to cynicism. More to the point is the concept of maintaining appropriate channels at all times for the raising of questions related to the work problems of staff at any level in the organization. In effect, the approach would be to seek systematically such evaluation of work tasks, procedures, and relationships

by personnel and to recognize this process administratively as desired behavior, without having the executive branch of the organization abdicate its authority for decision-making.

Client or consumer participation. In considering participation in policy formulation and in raising questions at various levels, one must not overlook client, consumer, or patient participation. A long-standing practice in membership organizations such as group service agencies has been to involve clientele in program-planning, although the extent and modes of participation may often merit re-examination. Now there is increasing attention to the importance of participation among resident populations, such as those of general, rehabilitation, and mental hospitals. Whether and how such participation is possible for nonresident groups, as in casework agencies, remains to be seen.

Participation of clientele does not have to be complicated. One might remind oneself that retail customers "participate" when they are asked to register suggestions on cards, in restaurants, or in airplanes, and such participation can be quite valuable to an organization if the cards are actually read and followed up. Clients in agencies participate when they are involved in the follow-up study of practice. The use of client or consumer participation as a gimmick to demonstrate organizational interest and response to the "voice of the people" can in the long run only be self-defeating, since even the public relations value of these devices will eventually suffer, and the chances of actually utilizing the opinions of consumers will be minimized. What is much more to the point is, first, the right of the consumer to participate at his level of legitimate interest and experience; and second, the contribution he can make by such participation, even if it is elicited by simply asking in a systematic way what he thinks of the service and whether he has any suggestions. Robert Vinter has stated that the client is "lowest on the authority continuum" in social agencies.[6] This is true, by and large. It hardly means, however, that the client has nothing to contribute in the formulation of policy. It means, rather, that the opportunity to participate has to be structured for the client, and that this opportunity should be meaningful.

COMMUNITY

Accountability. The tendency that can develop in agencies toward self-protectiveness and insularity *from* outside community pressures can lead to inadequate discharge of the agency's responsibility to be accountable for its activities. This source of strain can to some extent be solved by executive decision. A clear understanding is necessary of the public or publics to whom reporting should be made, as well as the development of appropriate means for such reporting. In the absence of such measures for accountability, accumulated pressures for reporting may press on the agency at a point when it is least prepared to meet the demand. While public relations is an element in accountability, it should not be construed as synonymous with it; rather, the genuine right of groups to know what is appropriate and legitimate for them to know and react about should be emphasized. Not only external groups such as legislatures or chests and councils are involved in agency accountability, but departments and total staff of the agency as well.

FORMAL AND INFORMAL ORGANIZATION

Philip Selznick has stated three hypotheses in his article on "An Approach to a Theory of Bureaucracy."[7]

1. Every organization creates an informal structure.

[6] Robert Vinter, "The Social Structure of Service," in Alfred J. Kahn, ed., *Issues in American Social Work* (New York: Columbia University Press, 1959).

[7] *American Sociological Review*, Vol. 8, No. 1 (February 1943), pp. 47–54.

2. In every organization the goals of the organization are modified by the processes within it.

3. The processes in modification are effected through the informal structure.

Informal organization has been given considerable research attention, yet again relatively little has been said about action implications in the relationship of formal to informal structure. It may be noted that in referring to formal structure one is essentially speaking of what can be blueprinted in the organization: staff positions, lines of authority, job functions, procedures and regulations, committees, and so on. The informal structure includes virtually all else: sentiments, loyalties, informal interaction, friendships, animosities, and cliques.

When the goals of the informal organization are the same as for the formal, one has the essential precondition of high morale. It is generally conceded that such a situation contributes to the efficiency, productivity, and flexibility of an organization. People will do more, work more, think harder, for the organization when its purposes are incorporated not only in the formal tasks but in the sentiments and personal orientations of those in the organization. When the methods and goals of the formal organization are not shared by the informal, more rigid controls become necessary, and the investment in management activity tends to be toward organizational control and overcoming impediments to carrying out the organizational objectives. This is the situation, for example, in most correctional institutions or in any organization which for longer or shorter periods of time contains disaffected, alienated employees, or resident populations of patients or inmates with sentiments or aspirations in conflict with those of formal authority.

For the executive and management group there is the recurrent dilemma in most noncustodial organizations of having to be sensitive to the informal structure without interfering with it or attempting to manipulate it. Such manipulation is not only ethically questionable, but in the long run destructive to organizational interests. It is important to recognize, at the same time, the danger inherent in permitting formal processes and decisions to be usurped by the informal structure. One can accept the hypothesis that processes of modification in the formal organization are constantly being effected through the informal structure. Ideas, sentiments, and biases within the informal structure have an effect, sooner or later, on changing conditions within the formal structure. However, for an organization to remain viable and in control of its destiny without being seriously beset by nonrational influences requires that the formal structure be recognized as superordinate. It thus becomes the responsibility of all personnel to see that decisions that belong within formal channels are not made within informal groupings, and to make sure that policy questions that should be raised become located in proper administrative channels. If there are no such channels available, staff can seek to have them created. Should informal groupings be able to manipulate the formal structure, the results—with the best intentions in the world—can become corrosive to the organizational fabric.

One may note, therefore, at least two directions for executive and other personnel in an organization to follow, from an understanding of the inherent relationship between formal and informal structure:

1. The executive should not seek to manipulate the informal structure. He can be sensitive to its climate through the normal processes of administration without seeking to intrude or to develop special channels of communication.

2. For all staff it is important to locate recommendations and policy questions within appropriate levels and channels of the organization, whether or not they originate within the informal structure, in order to safeguard the long-range interests of organizational purposes, processes, and stability.

CONCLUDING OBSERVATIONS

This paper has summarized from existing theory certain predominant strains arising from bureaucratic organization. In relation to each, inferences were drawn as to the direction of administrative practice in preventing, mitigating, or compensating for such strains. It is understood that no organization can be stress-free, and the direction of resolution of bureaucratic strains should be consistent with bureaucratic organization. The importance of supervisory evaluation through the entire line organization in mitigating stress and the concept of relevant participation in policy formation were emphasized.

While the focus of this paper has been the bureaucratically organized agency, the theory has implications as well for the nonbureaucratic agency, characterized by relatively small size, less defined roles, and more informality in relationships. The inherent strengths of such organizations at their best lie in their high potentiality for flexibility, responsiveness to change, and the use of imagination and creativity. The inherent potentialities for weakness lie in the dangers of instability, role confusion, stress on the maintenance of affable personal relationships, and ambiguity of norms for both personnel and consumers or clientele. The virtues of informality are also its dangers if relationships are strained or systematic procedures neglected. The potential organizational assets and liabilities of the nonbureaucratic agency are thus the reverse of those in the bureaucratic agency. The direction of administrative implications would be to maintain enough structure to minimize role confusion, personnel insecurity, and policy ambiguity without sacrificing the essential values of adaptability and informality. Although concepts related to the nonbureaucratic agency cannot be elaborated in this paper, they should not be overlooked in our attention to bureaucratization, and merit development in their own right.

BY C. B. OLMSTED

Some Management Principles of Staffing Social Welfare Organizations

OVER THE PAST nine years in Cleveland the influx into social welfare planning committees and agency boards of a substantial number of business personnel specialists has directed the thinking of social welfare administrators regarding the staffing of their respective organizations toward the experience and practices of business administration. These sidewise glances have in some instances reconfirmed the soundness of methods long established in the health and welfare field, while in other situations they have brought about changes in the approach of social welfare administration to its responsibility for recruiting and developing the agency staff. This paper will attempt to summarize certain principles of staffing believed to be sound, which are being applied or tested currently in Cleveland social agencies. For some of these principles a little of the discussion which is to be found in the literature of business management will be cited.

The ultimate objective of management in all activities related to staffing an organization operating in the field of health and welfare is the effective and efficient fulfillment of the purpose and function of the organization.

This principle may seem so obvious as to require no explicit reference here. Perhaps this is part of the reason why it seems to be so easy to omit its application as the primary test of policies and practices relating to such matters as the agency manning table, structuring of jobs, salary ranges, promotions and salary increases for individual employees, and the determination of personnel practices.

Perhaps a more basic reason why purpose and function are not used more frequently as a yardstick to measure the effectiveness of social agency administrative activities is the difficulty in translating the fundamental reasons for the existence of the organization into qualitative and quantitative terms sufficiently specific, understandable, and acceptable so that the effectiveness and efficiency with which they are expressed can be readily determined.

For purposes of this discussion it will suffice to give emphasis to the fact that all sound staffing programs are built upon a foundation of management determinations of agency purpose and function. Changes in existing staff assignments, additions or deletions of positions, or the development of entirely new job assignments should reflect as clearly as possible the specific requirements of the agency program.

PROGRAM NEEDS AND STAFF

One of many possible corollaries to the first principle is so important in a consistent approach to staffing the agency, and so often ignored in practice, that it is stated here as a second principle. Faced always with an excess of demands for service beyond the resources of any effective social agency, *management needs to determine*

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with each shift in emphasis of the program the kinds of jobs required and the number of persons currently needed for each job.

This statement assumes that responsible social agency management cannot wait until it has a staff of sufficient size and competence to fulfill its community function completely before determining how its presently budgeted staff positions should be deployed, since that summit will never be reached. Rather, the administration should project, probably for at least the fiscal year, and on the basis of a detailed analysis of current agency function, the kinds of jobs and number of positions implied by this functional analysis. Such a projection in the business field is sometimes referred to as a *manning table.*

Once developed, the manning table is useful as an administrative tool in keeping staffing activities closely related to agency function. It may call attention, for example, to the fact that a proposed staff promotion which otherwise would seem desirable is not yet timely in terms of the service goals which the organization has set for itself. Untimely promotions, or the hiring of more high-priced personnel than the manning table calls for deprives the agency of funds needed for other salary-administration purposes.

Along with the development of the manning table goes the analysis and description of the jobs for which it calls. *Jobs should be structured in terms both of the requirements of agency purpose and function and of the growth potential for the persons who will be required to perform them.* The recent literature of business management contains many references to the importance of building into the job assignment possibilities for worker satisfaction. Drucker, for example, in a chapter entitled, "Employing the Whole Man," comments that one does not " 'hire a hand'; its owner always comes with it." [1] He goes on to say:

> The work . . . must encourage the growth of the individual and must direct it . . . otherwise it fails to take full advantage of the specific properties of the human resource. This means that the job must always challenge the worker.[2]

Recognizing professional employees as a group in industry whose needs for job satisfaction require special attention in this setting, Drucker suggests a brief and interesting list of these needs, which includes the following statements:

> He must have opportunities for promotion as a professional employee and individual contributor.
>
> He must have financial incentives for improved performance and greater contribution as an individual contributor.
>
> He needs professional recognition both inside the enterprise and in the larger community.[3]

Drucker comments upon the professional job in industry as one for which high standards should be set by supervision in such a way as to leave responsibility for the methods by which the required results are obtained up to the professional employee.[4]

In a paper on the same theme, Ohmann talks about "a whole job as consisting of planning, doing, and evaluating." [5] Traditionally, he says, industry has tended to assign to its employees only the doing, and

> . . . when jobs are structured in this manner we do not employ the *whole man* with his capacity to imagine, think, evaluate, make judgments and decisions, and respond to the deeper emotional satisfactions that come from challenge.[6]

The primary solution which Herzberg (to whose research reference will be made again) suggests to problems of low morale

[1] Peter Drucker, *The Practice of Management* (New York: Harper & Brothers, 1958), p. 262.

[2] *Ibid.*, p. 266.

[3] *Ibid.*, pp. 333–334.

[4] *Ibid.*

[5] O. A. Ohmann, "The Whole Man on a Whole Job." Paper presented to the Annual Pipe Line Conference, American Petroleum Institute's Division of Transportation, Cleveland, May 6, 1957.

[6] *Ibid.*

and productivity lies in the restructuring of jobs.[7]

This area of structuring of jobs to utilize the resources of the whole man is one in which traditionally, at least, the health and welfare field may have been possessed of greater insight than the business field. Creative work opportunities in social agencies may go a long way to explain how these voluntary and tax-supported organizations have succeeded in attracting as many competent individuals to their staffs as they have. Whether or not this has been so, management in the health and welfare field can afford to be reminded by the experience of industry that efficiency dictates concern for the growth of the worker as he furthers the objectives of the organization through performance of his job.

It is interesting to note here in passing that none of the industrial writings with which the writer is familiar—which advocate the structuring of jobs so that they will command the dedication of their incumbents—so much as hint that once this kind of opportunity is provided it will no longer be necessary to provide as adequate financial compensation for these jobs as was required formerly. On the contrary, as already noted in one of the references cited, financial incentives commensurate with the demands of the job are viewed as a very important, if not essential, basis for expectations of efficient and effective work.

SOUND PERSONNEL PROGRAM

The ideal personnel policies and practices are those which: (a) are based on an understanding of what employees want in their jobs, (b) provide neither less nor greater tangible rewards and benefits than are necessary to competent fulfillment of the purpose and function of the particular organization, and (c) are accepted by both the staff and board of the agency.

It is not the purpose of this paper to list or discuss in detail specific personnel policies and practices for social welfare organizations. Such lists and discussions are readily available from professional associations, national agency headquarters, journals, and so on. One concise summary of areas to be considered in formulating personnel policies may be found in "Personnel Relations Series," No. 2, published in 1959 by the American Hospital Association.

It may be useful here to draw attention to the criteria suggested above for development of ideal policies and practices in this area, although no organization claims to have achieved the ideal program. The first of these criteria has to do with what employees want in their jobs. This subject has been explored in numerous studies in the business field. The following ranking by employees of significant factors on the job is typical of the findings of many of these studies.[8]

1. Opportunity for advancement
2. Steady work
3. Opportunity to use own ideas
4. Opportunity to learn a job
5. Opportunity to be of public service
6. Good boss
7. High pay
8. Good working companions
9. Comfortable working conditions
10. Clean work
11. Good hours
12. Easy work

Recent research by Herzberg and his associates at the University of Pittsburgh, which included an evaluation of all previous industrial studies of morale and motivation, concluded that "there was a difference in the primacy of factors, depending upon whether the investigator was looking for things the worker liked most about his job or the things he disliked."[9] Careful interviewing convinced Herzberg that these variables do not operate on a continuum.

[7] Frederick I. Herzberg, *Motivation to Work* (New York: John Wiley & Sons, 1959).

[8] Joseph Tiffin and Ernest J. McCormick, *Industrial Psychology* (4th ed.; New York: Prentice-Hall, 1958), p. 325.

[9] Herzberg, *op. cit.*, p. 7.

Instead, while factors could be found which lead to employee dissatisfaction, elimination of these negative factors (such as low salaries, poor working conditions, and poor interpersonal relationships with supervisors) did not necessarily or usually lead to job satisfaction. Job satisfaction developed as a different set of creative factors was emphasized, including achievement, recognition based on achievement, possibilities for creativity in the work itself, responsibility delegated, and advancement potential. A critical evaluation of such industrial relations research can be helpful in the devising of essential but not elaborate personnel policies for social welfare organizations.

The second criterion of sound personnel policies and practices concerns the provision of neither less nor more tangible rewards and benefits than necessary. Implications of several of the business field sources already quoted are that industry is already caught in a mesh of costly, hygienic efforts to make dull work clean, only to find that the answers to their problems lie elsewhere. This suggests that, faced with limited resources in the social welfare field, we should make haste slowly in efforts to catch up with the fringe-benefit program of industry.

The area in which we *do* have to catch up is salary administration. Research on the effects of prevailing salary policies in the welfare field is limited but consistent in its findings. Kadushin's comprehensive study of career choice determinants among social workers indicates that 45 percent of voluntary separations from California county welfare departments in 1953–54 were due to low salaries, and of this group 74.3 percent of male dropouts gave this reason. Another 32.6 percent of the same sample indicated that the future offered by the field was too limited.[10] Thus thousands of untrained workers, many of whom might be potential recruits for professional education, are lost to the field because of low salaries.

In 1956 44 percent of so-called "preventable separations" of YMCA workers gave "inadequate salary" as the primary reason for separation.[11] This number represented an increase over the percent of such separations for this reason in 1951. Other indications of the negative effects of inadequate salary practices are to be found in high turnover rates revealed in studies by national associations of social welfare agencies and the continuing failure of the field, in a period of an expanding market for social work skills, even to supply enough qualified recruits to replace personnel who retire from practice.

The solution to the problem of inadequate salaries, especially in the voluntary social welfare field, is basically one of management's unwillingness to face up to the problem, and only secondarily one of a lack of resources. Only when boards and executives of social agencies become convinced that they are providing less in the way of financial incentives and rewards than it takes to accomplish the purposes of their respective organizations will administrative steps be taken to make more effective use of whatever amount of funds the agency has to spend on personnel costs. Without management's willingness to pay what it costs to maintain an efficient and effective staff, additional dollars available for salaries may actually foster inefficiency and incompetence in the field.

The third ingredient of the ideal personnel program involves its acceptance by staff and board. The real achievement of the 1956 pilot study of casework jobs in Cleveland is that it has been studied and used extensively as a guide to appropriate salary levels by personnel and finance committees of agency boards, by staff personnel committees, by union negotiating teams on both sides of the table, and by

[10] Alfred Kadushin, "Determinants of Career Choice and Their Implications for Social Work." Paper presented to the National Conference on Social Welfare, Philadelphia, 1957.

[11] "Salary Experience of YMCA Secretaries," 1957–58 study report (New York: National Council, YMCA, 1958).

budgeting groups responsible for allocating both tax and voluntarily contributed funds for salary administration.[12] Its widespread acceptance created an effective demand for extension of the method to include all jobs in organizations throughout Welfare Federation member organizations, a project which was funded and commenced in April of 1959 and is now nearing completion.

The point is that, important as the findings and recommendations of these projects may be, the most significant thing about them is the local acceptance and application of their results by all parties concerned. It is significant too that this acceptance is currently so pervasive among both volunteer and professional leaders of the social welfare field that it tends to sweep along both business and social welfare leaders who have little understanding of the methods employed in the studies. It is widely agreed in Cleveland that efforts to implement the recommendations of these projects are not only efforts to raise salaries, but also steps in the direction of efficiency and effectiveness of social agency operation.

The community-wide nature of these projects, of course, lends a momentum to the favorable attitude toward them which would be difficult to reproduce on the same plane in the case of a similar type of undertaking by an individual agency. The genesis of this attitude, however, is in the community organization process by which these projects were conducted, and this process can be as much the property of executives of direct-service agencies as of community planning bodies. To be effective, agency personnel policies require development by a process which involves the directed interest and activity of staff and board to such an extent that acceptance of the results of their deliberations is built into every step of their formulation. Appropriate participation by as many as possible of those to be affected by these policies is the key to their ultimate effectiveness.

[12] *Pricing Casework Jobs* (Cleveland: The Welfare Federation of Cleveland, 1956).

STAFF DEVELOPMENT

"Management is the development of people and not the direction of things."[13] Staff development is of primary importance in effective social agency administration. It is not something which administration has either the responsibility or the capacity to do for its employees. *Rather, management should provide opportunity for growth on every job, and its success in appraising staff performance and stimulating and facilitating staff development may be regarded as a major indicator of executive competence.*

A major step in successful staffing of a social agency is the development of qualitative and quantitative standards of productivity for jobs, and criteria for appraising the performance of the worker in relation to these standards. Many industrial systems for appraisal of worker performance utilize a group discussion method, involving the immediate superior of the man being appraised—often the superior's boss—and at least one other person who knows the work of the man in question. "The central point of the discussion by this appraisal group is 'how is this man performing on his job and what results is he getting.' "[14] The group is instructed to emphasize a man's effectiveness or ineffectiveness in relation to the requirements of the job, rather than his personal qualities. Follow-up counseling with the individual is directed toward pointing up (a) areas in which he may strive productively to increase his effectiveness in relation to the objectives of the organization, and (b) the agency resources, often rich and varied, at his disposal for these purposes.

Performance appraisal is characteristically oriented to helping the worker do his present job better. Of course, it also serves

[13] Lawrence A. Appley, "Management the Simple Way," *Personnel* (January 1943), p. 595.

[14] O. A. Ohmann, "Executive Appraisal and Counseling—the Core of Management Development Effort." Talk given at the Detroit Industrial Relations Conference, Bureau of Industrial Relations, University of Michigan, Ann Arbor, January 9, 1956.

as the major guide to the executive in relation to filling position vacancies from within his organization. When such promotions introduce or add to the supervisory responsibilities of the individual, factors in the appraisal relating especially to these responsibilities require careful attention. Katz suggests a breakdown of appraisals into three broad categories which, while expressed in terms that may not lend themselves perfectly to use in the human relations field, will serve to call attention to the essentially different skills required at different levels of the organization. *Technical skill* Katz describes as concerned with the mechanics of the job; *human skill* leads to effective group membership; and *conceptual skill* recognizes interrelationships and takes such action as will result in the maximum good of the organization.[15] This breakdown helps to highlight the fact, not infrequently overlooked in making promotions within any organization, that an individual may become most proficient as a professional worker without necessarily having developed the skills required to be an effective supervisor or administrator.

The platform upon which the staff-development program rests is, of course, the quality and quantity of the recruitment and selection effort of the agency. No amount of training can overcome the failures of the selection process. In recent years this problem has at times seemed the Achilles heel of staffing, because of the shortage of qualified personnel available. It should be noted that, theoretically at least, it is easier to recruit and select for a job opportunity than for something which is merely a job opening.

For effective and efficient fulfillment of the organization's purpose and function *it is important to attract and keep competent and satisfied staff in every position required in the agency, whether professional or nonprofessional.* It has been said of building-centered group work agencies that their programs can be only as good as the job performance of the maintenance man. We hear stress placed by public relations experts on the importance to an organization of the manner in which the switchboard operator answers the phone.

What has been said here about structuring of jobs, personnel policies and practices, and staff development in social welfare organizations applies equally to jobs requiring professional and nonprofessional skills. This point probably requires little further elaboration if it is to be understood that management's concern for worker competence and satisfaction throughout the organization should stem from a concern which goes deeper than the efficient and effective program of the agency—namely, a concern for people as individuals. In fact, "integrated individuals fortified with an integrated philosophy are needed throughout the organization, not merely at the pinnacle." [16] With leadership of this sort at the top making a determined and continuing effort to attract and keep leadership of the same sort at all levels of the agency, it is unlikely that the value and potential contribution of any staff member will go unnoticed.

ANALYSIS AND RESEARCH

Statistical analyses and, where practical, research which indicate short- and long-range effects of staffing procedures upon the productivity of the agency are necessary management tools. Speaking of management activities in the established organization, March and Simon caution that

> . . . over time, the aspiration level tends to adjust to the level of achievement. That is to say, the level of satisfactory performance is likely to be very close to

[15] Robert L. Katz, "Skills of an Effective Administrator," *Harvard Business Review* (January–February), 1955.

[16] Marshall E. Dimock, *A Philosophy of Administration* (New York: Harper & Brothers, 1958), p. 41.

the actually achieved level of recent performance.[17]

Evidence of this descent to mediocrity in staffing procedures of social agencies is all too easy to find. One wonders, in hearing of the replacement of a retiring worker with a relatively inexperienced staff member who starts at twice the salary his predecessor was receiving, whether it was the salary structure, or maintenance of up-to-date standards of performance for the job, or perhaps the basic purpose and function of the agency that failed to receive proper attention during the tenure of the retiring staff member. (Do I hear someone betting that it was all three?)

There has been a tendency to think that because an organization exists to provide a service without a profit, such business methods as cost accounting cannot be applied. Yet gradually the field is moving in the direction of business-like procedures which aid in the evaluation of management activities such as staffing. This movement may contribute significantly to community acceptance of programs which, at the level of their professional content, are often beyond the comprehension of the large majority of their supporters. In the last analysis staffing procedures will not become scientific in the social welfare field any more than they have in business, despite all the studies that have been made. Staff assignments and personnel policies however scientific, Dimock maintains, are doomed to failure unless they can be justified on the basis of what they do "to the dignity of the individual and to his potential for growth." [18] As social agency management accumulates data about its staffing methods and their results, however, it may at the same time discover useful insights into means of increasing the effectiveness and efficiency with which its personnel are able to serve its clients and the community.

[17] James G. March and Herbert Simon, *Organizations* (New York: John Wiley & Sons, 1958), pp. 182–183.

[18] Dimock, *op. cit.*, p. 171.

BY HERBERT S. STREAN

Treatment of Mothers and Sons in the Absence of the Father

THE EXTENSIVE IMPACT of divorce and separation on the emotional life of a developing child is well known. The obstacles to be overcome and the burdens to be assimilated for the remaining parent and his child have been well described and documented in the literature.

In reviewing the studies on children who grow up without one parent, Neubauer found that most attention appears to have been devoted to the pre-oedipal period, particularly to the absence of mothering in the need-satisfying phase.[1] Investigations by Bowlby, Glaser, and Anna Freud "demonstrate the inexorability with which the infant requires instinctual satisfaction through one consistent empathetic mother, and how failing this through separation from the mother in the first year of life, his future may be threatened by vegetative dysfunction, disturbances in object relations and ego structure." [2]

While specific clinical studies describing the vicissitudes of treatment with fatherless children in general and the fatherless son in particular are sparse, the available material will bear brief review. In 1905 Freud, in his *Three Essays on the Theory of Sexuality,* reported the results of his investigations on patients with hysteria. He stated that "the early loss of one of their parents, whether by death, divorce, or separation, with the result that the remaining parent absorbs the whole of the child's love, determines the sex of the person who is later to be chosen as a sexual object and may thus open the way to permanent inversion." [3] In his study of Leonardo da Vinci, whose illegitimate birth deprived him of a father's influence until perhaps his fifth year and "left him open to the tender seductions of a mother whose only solace he was," Freud describes a type of male homosexuality in which etiological factors are the maternal seduction of a son because of the libidinal shift from husband to child and the absence of a paternal influence on oedipal development.[4]

Ferenczi in discussing the early histories of male homosexuals emphasizes a fixation on the lost father due to the absence of necessary and unavoidable conflicts be-

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[1] P. Neubauer, "The One-Parent Child and His Oedipal Development," *Psychoanalytic Study of the Child,* Vol. 15 (New York: International Universities Press, 1960).

[2] *Ibid.,* p. 287. *See also* J. Bowlby, *Maternal Care and Mental Health,* World Health Organization monograph (Geneva, 1951); K. Glaser and L. Eisenberg, "Maternal Deprivation," *Pediatrics,* Vol. 18, No. 2 (April 1955); and A. Freud, "Observations on Child Development," in *Psychoanalytic Study of the Child,* Vol. 6 (New York: International Universities Press, 1951).

[3] S. Freud, *Three Essays on the Theory of Sexuality* (standard ed.; London: Hogarth Press, 1953), Vol. 7, p. 563.

[4] *Ibid.*

tween father and son.[5] Fenichel points to the reinforcement of the inverted oedipus complex in boys by the fantasy image of an absent father, and describes the guilt engendered by fantasy fulfillment of oedipal wishes when the same-sexed parent leaves the familial scene.[6]

Neubauer in his recent paper, "The One-Parent Child and His Oedipal Development," stresses the pathogenic potential of an absent parent and underlines the profound conflicts in sexual identification and superego formation found in the children he studied. While significant variables are seen—namely, the timing of the loss and the relationship of the child's sex to the sex of the missing parent—"the single parent's over-cathexis and consequent seduction of the child described by Freud may be considered prototypic." Further, "the fantasy objects of immensely idealized or sadistic dimensions which replace an absent parent are nearly ubiquitous."[7]

In "A Pattern of Mother-Son Relationship Involving the Absence of the Father," Wylie and Delgado of the Worcester Youth Guidance Center comment that nearly all the twenty boys they investigated showed learning problems and had enormous difficulty handling their aggressive impulses.[8] The relationship between mother and son was described as "intense, highly sexualized, and full of hostility." The mothers had many conflicts about their roles as women and mothers and had conflicting attitudes toward men in general; their sons seemed to be used by them to solve these conflicts. Dominated by a "vengeful, competitive attitude toward males and by a strong wish to be a man, these women looked upon their sons as the fulfillment of this wish." The boy's role was that of the mother's dangerous, aggressive penis. The boys also represented the bad part of the mother which "must be displayed, fought and sometimes destroyed or confined." Wylie and Delgado reported that their attempts to help these patients were not very successful. Most of them either rejected treatment outright or withdrew after a few visits. Several factors which may have contributed to their poor therapeutic results are proposed. (1) These are often quite severely disturbed people, and the degree of their pathology might be expected to limit therapeutic work. (2) Most of them were poorly motivated for therapy and came in at a time of crisis and under external pressures. (3) These women have great difficulty in giving up their sons, who serve as their sexual objects. The boys, too, struggle to maintain the situation and view the treatment as a threat to this source of pleasurable gratification.[9]

The dubious prognosis for the mother-son constellation described by Wylie and Delgado was reaffirmed by the child guidance personnel with whom they shared their findings at an Orthopsychiatric meeting in 1958. The consensus at this meeting was that, despite the well-intentioned efforts of many child guidance clinics and family agencies to involve this type of "broken" family in treatment, the results have not been proportionate to the therapeutic zeal invested. The mother, who frequently uses the son unconsciously as a psychological spouse, is most resistant to releasing him to another adult for treatment. "I want my son to myself, he is my whole life," is the message she seems to convey. She refuses to surrender her son to one person in the individual treatment relation, with its potential for exclusive possession, for it may stir up her own unresolved strivings and attachments to the most significant persons in her own

[5] S. Ferenczi, *The Nosology of Male Homosexuality: Sex in Psychoanalysis, I.* (New York: Basic Books, 1950).

[6] O. Fenichel, *The Psychoanalytic Theory of Neurosis* (New York: W. W. Norton & Co., 1954).

[7] Neubauer, *op. cit.*, p. 292.

[8] H. Wylie and R. Delgado, "A Pattern of Mother-Son Relationship Involving the Absence of the Father," *American Journal of Orthopsychiatry*, Vol. 29, No. 3 (July 1959), pp. 646–649.

[9] *Ibid.*

life.[10] The son, although forced to fuse two objects into one, submits to his mother's wishes and resists therapy, as well. He supports the well-proven child guidance axiom that the child and his functioning are expressions of the parents' egos.[11]

MOTHER-SON SYMBIOSIS

Our own experience in the Manhattan Office of the Madeleine Borg Child Guidance Institute seemed to coincide with those of others. Consequently we began to investigate intensively this type of family constellation and our therapeutic approaches to it. We can say upon review and reflection that the mother-child relationship appears to be a form of *folie à deux*. Just as "the paranoid develops for himself a partner, a paranoee, or an alcoholic man is married to a certain type of woman who will, against all expectations of her logically minded friends who want to save her, return to him and nurse him until he is strong enough to go on a drinking binge again," [12] perhaps the mother unconsciously needs to provoke a similar situation with her son.

As the mother, in many cases, unconsciously sought a separation or divorce from her husband, does she not recapitulate this same phenomenon with her worker and want to divorce him as well? Further, as any human organism needs defenses for protection, may we not look at an emotional symbiosis as similar to a defensive layer of skin which, if pierced, will bleed? May not treatment symbolize for the mother and son we are studying a threat to their psychological equilibrium—the threat of disrupting a needed relationship? Upon careful scrutiny of our own reactions to these mothers, it seemed imperative to look upon them not as evildoers—which unfortunately we did at times—but as unhappy human beings caught in the net of their own frustrated wishes.[13]

As Feldman *et al.* in "A Casework Approach in Apparently Unreachable Cases" have pointed out,

> A fundamental problem in cases of extreme resistances is the difficulty of the client in dealing with his destructive and libidinal impulses and his need—instead of feeling and expressing them in language—to act them out—mainly in the form of resisting help. He has not received the necessary parental protection which would have allowed him to integrate his infantile strivings in a more mature way and in harmony with the more adult side of his personality. . . . Though he remains emotionally incapable of fulfilling his parental role, he is compelled to present himself as a capable, self-sufficient parent. In this way, he denies the "child" in himself, as well as the need for an outside protective figure.[14]

As Love and Mayer suggest, such protection becomes available when the worker places himself where the parent stands emotionally, namely, as a child. He does not try to enlist the co-operation of an adult ego which, in fact, does not exist. He does not ask for responsibility prematurely, he does not burden the client with early interpretations, and does not show the reality situation as long as the client is not able or does not wish to see it. He allies himself with the client psychologically, looks

[10] L. Rosenthal *et al.*, "Family Relations as a Consideration in Selecting Children for Activity Group Therapy," *International Journal of Group Psychotherapy*, Vol. 10, No. 1 (January 1960), p. 79.

[11] O. Sternbach, "Arrested Ego Development and Its Treatment in Conduct Disorders and Neuroses of Childhood," *The Nervous Child*, Vol. 6, No. 3 (July 1947), p. 307.

[12] L. Knoepfmacher, "The Length of Treatment in a Child Guidance Clinic," *Jewish Social Service Quarterly*, Vol. 26, No. 2 (December 1949), p. 185.

[13] L. Knoepfmacher, "Child Guidance Work Based on Psychoanalytic Concepts," *The Nervous Child*, Vol. 5, No. 2 (April 1946), p. 210.

[14] Y. Feldman *et al.*, "A Casework Approach in Apparently Unreachable Cases," pp. 11–13. Paper presented at a meeting of the American Orthopsychiatric Association, New York City, March 1958.

at the world from his viewpoint, speaks his language, and then can convey to him that it is not a sign of damage or inadequacy to seek infantile gratification and to continue the search for a healthy parent.[15]

ONE THERAPIST FOR MOTHER AND SON

In formulating our hypothesis further, in order to support the defenses of the mother who wants "my son to myself" and of the child who attempts to satisfy his mother's wishes, we decided that to preserve rather than attack the symbiosis we would not "divide" the case. We felt it would be less threatening to the symbiosis for the mother to see the very person who treats her son. This enables her to have consistent access to this person, thus diminishing her fear that he will be alienated from her. Also, we speculated that if we offered the mother and son a male worker, would we not be reconstructing symbolically the family before it was disrupted? In a nonthreatening relationship, could not the mother begin to invest some of her libidinal and aggressive drives in the therapeutic relationship instead of acting them out with her son? Would not the son gradually receive permission to enjoy a father figure if the mother could slowly transmit new heterosexual values to him?

These are the questions we asked. The following three cases will attempt to illustrate our experience within the framework of our conceptual thinking.

Case 1. Mrs. A, a middle-aged widow, divorced her husband when she was 35 years old. Although her marriage was always stormy, domestic harmony was completely unknown shortly after the birth of their son, which occurred three years after the A's were married.

Mrs. A was advised by her son's guidance counselor at school to seek therapeutic help for him. According to teachers' reports Robby, aged 13, appeared withdrawn, showed little spontaneity, spent much time immersed in fantasy talking to himself. His characteristic way of relating to peers was to be the "fall guy"; he submitted to their wishes when they suggested that he insult a teacher, lift a girl's skirt, or swear. Although the counselor suggested the idea of therapy as a possibility, Mrs. A responded to his proposal as if it were a court summons and called the clinic immediately.

In her initial interviews, Mrs. A was very quick to defend her son. "He has had a hard life and you can't expect too much from him. He has no father and I'm his whole life. I try my best and when he's lonely I get into bed with him and cheer him up. The people at the school are making a big mishmash out of this." When the worker agreed, saying that frequently school personnel do not understand well-meaning mothers who are very attentive to their sons, Mrs. A condemned the school for "making me think that my Robby is a problem." She damned guidance personnel and school personnel, and felt that "too much was made out of this psychiatry business. "I can take care of Robby by myself. There are a lot of people who don't understand mothers and sons like me. I love my boy and nobody will take him away from me." When the worker stated that he couldn't think of anything much crueler than taking away Robby from his mother, Mrs. A remained silent for a few moments and then burst into tears. "People just don't understand. They don't understand," she sobbed. The worker said that he would like to understand.

Mrs. A went on for several sessions again damning educators, therapists, social workers, and others. When this was not challenged or interpreted, Mrs. A began to speak of her own history. "I've had to fight my way in life. Nobody cared about me. Nobody understood. My parents pushed

[15] S. Love and H. Mayer, "Going Along with Defenses in Resistive Families," *Social Casework*, Vol. 40, No. 2 (February 1959).

me and I had to please them. I married the man they wanted, not who I wanted. I did everything for them." The worker took note of Mrs. A's experiences of being frequently squelched, ordered around, and defeated, and how this was being repeated with him. She responded during her fifteenth session, "Oh, I forgot to tell you. I let Robby join the Y on his own. I think it's good for him to do things on his own."

In subsequent interviews Mrs. A reported that Robby wanted to start seeing "that Strean guy." However, even when the worker repeated Mrs. A's previous doubts about psychotherapy, she said with conviction, "I am all for it, but Robby will decide for himself. I'll help him if he wants it."

This clinical illustration highlights some of the initial problems we have in treatment with the mothers under investigation. Incapable of fulfilling their parental roles appropriately and tending to see their sons as extensions of themselves, these mothers frequently project their inadequacies onto other people. To deny the infantile parts of their own characters and remain unaware of their symbiotic ties with their sons, they present themselves as self-sufficient people. As we observed in the case just described, the worker did not focus on Mrs. A's anger or her role in the parent-child relationship, for it would only have been perceived by her as a threat to disrupt her psychic equilibrium. Rather, he attempted to protect her archaic defense so that he could be perceived as a person who sympathetically listens to expressions of wishes and fantasies and does not attempt to interpret irrational ideas. As the worker also permitted Mrs. A's expressions of rage, and could slowly help her differentiate herself from her son, she was able to release some control over him and permit his entrance into the Y and eventually into treatment.

We learn from Mrs. A that through our protection of her defenses, her needed symbiosis, and her use of projection she could see us as an ally. However, despite our occasional successes in involving the mother in a relationship by offering her enough protection to enable her to release her son for treatment, we often observe rigid, seemingly impenetrable resistances erected by the son.

Case 2. Howie B, a 12-year-old boy, was referred for treatment by school personnel. Provocative and unruly in the classroom, he was failing most of his subjects despite a high I.Q. His peers frequently rejected him because of his clowning, baiting behavior. At home, he either watched television or talked to his mother about how his father "never gave me a break." Although the parents decided on a formal separation when Howie was 10 years old, prior to that there had been numerous separations and reconciliations. As the displayed expression of family disturbance, Howie often carried out the unconscious mandate for instigating arguments and prided himself on his importance—"they fight over me."

Although Mrs. B was extremely resistive to receiving help for herself and Howie, after much support she was able to release him for treatment. In Howie's initial interviews he immediately attempted to involve the worker in arguments and fights. He made it clear that he had won an oedipal victory and that he could beat the worker very easily. "Look, Streanbones," he remarked during his sixth hour, "I've got your number! You think you can straighten me out? Well, you're mistaken! I've got a good deal all the way around and I don't care what the school says. I've got it made there, too. You can't win." Whereupon the worker casually remarked that Howie had been very capable in defeating his father, the school, and everybody else; it was a safe bet that even if the worker wanted to treat him, it was practically impossible. Howie laughed and said, "I guess you don't like to work too hard, huh?"

Since Howie's resistance to treatment was

not attacked and the neurotic gratification he received not interpreted, the therapeutic encounter did not appear too forbidding to him. He could come for his sessions because "there was nothing else to do." But in interview after interview Howie attempted to provoke the worker in a truly creative manner. "I tell my mother what a jerk you are and she's beginning to agree . . . you're so dumb, you couldn't harm a flea, String Bean." Session after session the therapist merely listened to Howie's remarks with mild interest and limited response. Occasionally he would say, "Oh, you can get rid of me any time. You did it with your own father," or "I'm sure you'll get your mother to fight with me. You are a master at that."

After seven months of coming to see the worker on a regular basis, Howie tried a new tactic. During one of the hours when Mrs. B was seeing the worker, Howie rapped on the door and demanded to see his mother immediately. While Mrs. B was ready to acquiesce, the worker sharply stated, "I am with your mother alone and we will not be interrupted or disturbed by you!" Mrs. B initially felt that the worker was being very cruel, but when he maintained a nondefensive attitude and attempted to explore her reaction, she began to recall how Howie would constantly interrupt her conversations with her husband and how he frequently entered the parents' bedroom, with no limits imposed on him. At the end of this hour Mrs. B declared, "You know, I can't exactly tell you why, but as I leave this office today I feel like a woman."

In Howie's next interview he yelled and screamed at the worker for not being able to share his mother with him for even a minute. "You want my mother all to yourself, don't you?" he belligerently queried. "At times I do," the worker replied. Though Howie spent several hours castigating the therapist for being so unfair, he finally modified his tone. "You're trying to be like an old man to me and show me that I'm a kid. You're a knucklehead but sometimes I see your point a bit."

As Mrs. B felt "more like a woman" with the worker and could put into words some of her libidinal and aggressive fantasies activated in the transference relationship, Howie could focus more on the gratification he received in "having my mother to myself and annoying you."

Although we have hypothesized that the mother and son, when seen by one worker and not divided, do not feel quite as threatened—and despite our belief that recapitulating the original family symbolically is, in a sense, gratifying to them—the parallel resistances of mother and son to relating to the male worker are none the less powerful. The following case illustration is typical in our experience. It highlights the similar resistances of mother and son.

Case 3. Mrs. C, an attractive woman of 46, had lived alone with her 14-year-old son Jimmy since he was 2 years old, when the parents divorced. She was referred to the clinic by her family physician when she discussed Jimmy's transvestitism with him. Jimmy, in addition, was doing poorly in his schoolwork.

Though both Mrs. C and Jimmy seemed eager for help, they quickly manifested strong resistances. Mrs. C complained bitterly about the fee, the appointment hour, the drabness of the office, the worker's poor choice of clothes, and his personal mannerisms. She felt that most men who enter the field of psychotherapy were probably homosexuals, and "anyway, how can a young kid like you help an experienced woman like me?"

Jimmy, too, didn't have much use for the worker. "I have gotten along without men all my life—who needs you?" He was quite sure that the worker had a concealed tape recorder and would use anything he discussed against him. Furthermore, he just didn't like school, and as far as his transvestitism was concerned, that was his business.

When the worker attempted to examine the fantasies ascribed to him without interpreting them and without counter-aggression, both mother and son felt that the worker had an "inferiority complex" and was too "insecure." When he showed interest, he was "overenthusiastic," and when he did not respond to their paranoid mechanisms he was experienced as cold, rejecting, and indifferent. After several months of these encounters the worker asked each of them what was going wrong. Most of his interventions seemed so unacceptable. To this Mrs. C replied by accusing the therapist of being too seductive and "trying to make" her, adding that "he certainly wasn't her type." She went on to relate that most men were no good—they had all disappointed her. Her grandfather, whom she truly loved, remarried after her grandmother's death and "this really hurt me." Her father was her mother's "puppy dog." "Mother's word was law and I got nothing. My husband was a 'shmoo,' and now most of my dates don't know which end is up. So you see, honey, you ain't got a chance."

Though Jimmy began to become interested in girls while his mother was focusing more meaningfully on the story of her heterosexual life, and although his schoolwork improved and his transvestitism diminished, as soon as the worker supported the C's temporary gains they both made strong bids to discontinue treatment altogether. Their wish to "go it *alone*—leave us *alone*" was ever present.[16]

SUMMARY AND CONCLUSIONS

Inasmuch as our study is still in its infancy, it is premature to state any definite conclusions. We are still involved in experimental investigation and need more clinical data and observations of others to support or refute our hypotheses.

While sufficient empirical data are lacking, we tend, after three years of study, to view the mother-son relationship under investigation as a powerful, albeit pathological, symbiosis. As a mutually gratifying network, neither mother nor son is eager for therapeutic assistance. They want to maintain the *status quo*, and when they do come for treatment it is usually under strong external pressure. The mothers have great difficulty in releasing their sons to another person because their psychological equilibrium, which is dependent on their sons, may be disrupted. The sons appear to be rewarded by their mothers for their unconscious sensitivity to their mothers' wishes, and they, too, resist therapy.

Looking upon these mothers not as evildoers but as human beings with conflicts is an often difficult but, of course, necessary attitude to maintain. Both mother and son must experience the worker not as an intruder who wishes to disrupt an emotional balance, but as a protector who seeks to help the mother and son preserve their relationship with each other. We have experienced a modicum of success when we have not "divided" the case but have centered the treatment of mother and son in one worker. If a part of the pair wishes to grow and enjoy family life, the provision of a male therapist helps them to re-establish a symbolic family. They are then able to modify to some extent their mutual need for and dependency upon each other.

The difficult but interesting mother-son constellation provides rich material for study and treatment, and challenges the therapeutic resources in us all.

[16] H. Strean, "The Use of the Patient as Consultant," *Psychoanalysis and the Psychoanalytic Review*, Vol. 46, No. 2 (Summer 1959), pp. 1–11.

BY DAVID SOYER

Reaching Problem Families Through Settlement-Based Casework

THIS SEEMS TO be the day of the "hard-core," "hard-to-reach," "multiproblem," and "hopeless" family. We are writing and saying much in our search for ways to help such families. This paper will attempt to show that the caseworker in the settlement house or community center is often in a particularly good position to aid these clients. Several facts about community centers, and casework within such settings, make this help possible.

No attempt will be made here to define such terms as "hard-core," "hard-to-reach," and so on, nor to apply such criteria as those of the New York City Youth Board to the cases selected for discussion. Suffice it to say that the clients under discussion are not victims of refined neurotic conflicts. Primitive in ego development, they are quickly overwhelmed by outside pressures and anxieties of the moment, and seek the worker out in their pain and panic; but once some kind of equilibrium is attained, they do not stay to "work through" their problems in order to avoid future crises. They seek quick and tangible help. Over and over again one senses, beneath a hostile veneer, an oral character; a client who never stops demanding, a mother who cannot give emotionally to her children but can only drain those around her of emotional sustenance. The dependency is pervasive and the client sucks from neighbors, shopkeepers, bartenders, and news vendors as well as family members and social workers.

In the midst of the world's largest and most cosmopolitan of cities, these people are surprisingly provincial. They rarely leave the immediate neighborhood, find it difficult to make telephone calls, and are sometimes panicked by official-looking documents.

There is no doubt that these families vary in reachableness and in the multiplicity of their problems. Nevertheless, they are recognizable as a group of clients. They are people with many and serious problems who are unlikely to seek help in an organized and consistent way and do not understand the sanctity of the weekly, scheduled interview. Rather "relationship" has meaning through practical social services.

These generalizations are similar to the observations of others working with such clients. Berta Fantl, in describing the personality structure of the hard-to-reach client, says, "Their judgment is poor and tolerance for anxiety is low. What we are seeing is 'instinctual' anxiety as different from anxiety of inner conflict . . . . The behavior of these clients is ego syntonic, more a way of life than a disturbing symptom . . . ." She speaks of their "passive dependent character traits." Her emphasis is on the lack of strength and consistency of the ego and

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superego.[1] Reiner and Kaufman, writing about character disorders in parents of delinquents, have described a similar group of clients.[2] Their earlier articles were helpful in both understanding and treating the clients discussed here.[3]

SETTING

The Manhattanville Community Centers, Inc., operate two centers, one situated in a low-income city housing project, the other a few blocks away. The community served is largely composed of Negro and Puerto Rican people, with some white and Oriental families. In addition to the large city housing project there is a new middle-income co-operative housing development. Older apartments and tenements range from deteriorated slum dwellings to more adequate middle-class housing. The socioeconomic backgrounds of the people are as diverse as the housing and racial make-up of the neighborhood. One of the aims of the centers is to encourage racial and social integration.

The centers' large group work department offers a full program of intensive group work to children, teen-agers, and adults, and operates a summer day camp. In conjunction with the Day Care Division of the Department of Welfare, the centers run nursery and school-age day care programs for the children of working mothers. A community organization worker staffs a "housing clinic" to help tenants of private apartments with their housing problems, and works with indigenous citizens' groups.

There is also a casework department consisting of two full-time, trained caseworkers, one of whom is director of the department, and two or three graduate students of social work. There is part-time psychiatric and psychological consultation. Approximately 150 cases are served by the department during the year, many of them of the type described in this article.

Referrals to the caseworkers come largely from other programs in the agency, although there are many self-referrals and referrals from other agencies (including public schools) as well as the manager of the city housing project. When the casework department was first established in 951 with a single part-time caseworker, its function was seen as referring troubled families and individuals found in the program to larger community family agencies or to clinics with treatment facilities. After a while it became clear that there were many such families and individuals who simply never reached the agencies to which they were sent. Among them were the group of families discussed in this paper. It was obvious that if these clients were to be helped at all, they must be helped within the centers themselves.

ADVANTAGES OF SETTING

"Neighborhood" has been defined in part as "bounded by the length of a child's legs —that is, the area in which preadolescent children can move freely."[4] This might be extended, for the subject under discussion, to the distance that obese and arthritic Mrs. "Hard-core" can walk or the area in which ghettoized Mrs. "Hard-to-reach" feels comfortable. Recently, a panel discussion of experts emphasized the principle of basing within the neighborhood

[1] Berta Fantl, "Integrating Psychological, Social, and Cultural Factors in Assertive Casework," *Social Work*, Vol. 3, No. 4 (October 1958), p. 33. *See also* articles in same issue by Kermit T. Wiltse and Ruth Ellen Lindenberg.

[2] Beatrice Simcox Reiner and Irving Kaufman, *Character Disorders in Parents of Delinquents* (New York: Family Service Association of America, 1959).

[3] Beatrice R. Simcox and Irving Kaufman, "Treatment of Character Disorders in Parents of Delinquents," *Social Casework*, Vol. 37, No. 8 (October 1956), pp. 388–395; by the same authors, "Handling of Early Contacts with Parents of Delinquents," *Social Casework*, Vol. 37, No. 9 (November 1956), pp. 385–392.

[4] *Neighborhood Goals in a Rapidly Changing World* (New York: National Federation of Settlements and Neighborhood Centers, 1958), p. 8.

our efforts to help the hard-core family.[5] One speaker, in fact, felt that problem families could be understood only in relation to problem neighborhoods and could be helped through a mobilization of all of the neighborhood resources.

By their very definitions, the community center and the settlement house are local operations. This is important not only because it brings the caseworker's office close to the client, but also because it leads to a certain familiarity and informality difficult to achieve elsewhere. There is nothing "downtownish" about this caseworker's office. The worker's schedule can be much more flexible. He can more easily see people in unscheduled appointments, and—since they have only come from around the corner—clients asked to wait while the worker meets an emergency can do their shopping, run to the laundromat, or attend to something else and come back in half an hour. If a client does not keep an important appointment, the worker can make a home visit without being hours away from his office. It is much easier here to adjust office routine to the timelessness of this kind of client than in most other settings. The closing of these cases is also less of an event than it would be in some other agencies. Our very accessibility and the vicissitudes in the lives of our clients lead to a rather free closing and reopening of cases.

As important as proximity in reaching our clients is the fact that the centers represent to them many sweet and helpful things in addition to casework. Day care for preschool and school-age children is one of the most profound and tangible services that can be offered to working or incapacitated mothers. The group work program means more than recreation; it means adults who understand the child and the teen-ager. The center is a cool haven, a place where one can escape the heat of the jungle that city streets often are. The center has bicycles and roller skates for use by children who do not have their own; it arranges for children to go to camp; it distributes food and other gifts, donated by various sources, to needy families at Christmas; and may serve to house refugees from a neighborhood fire.

As has been pointed out, there are implications in all this for early detection of problems, observation and treatment of the client in a natural environment, and the use of these multiple services in a planned and co-ordinated way to benefit the family.[6] Above all, the center is a normal and natural place to go, with or without problems. There is no stigma attached to coming to the center and little if any red tape or involved admission procedure.

CASE ILLUSTRATIONS

Typical of families with which the casework department works is the A family.

> Mrs. A is a tall, heavy-set Negro woman, quite articulate and intelligent. She moved into the low-income project two years after separating from her husband. The marriage had always been stormy. Mr. A had been hospitalized for a "nervous breakdown." There were four children, a boy now 11 and girls of 6, 4, and 3. The family lives on Mr. A's court-arranged contribution, plus Department of Welfare supplementation. The family came to our attention when Mrs. A applied for nursery school care for her oldest daughter. Client was not working but suffered from high blood pressure. The director of the nursery sensed Mrs. A's difficulties and referred ner to our casework department.
>
> Mrs. A is an explosive person, liable

[5] Meeting in April 1959 sponsored by the New York City Chapter, NASW, on the subject "What is Different About the Multiproblem Family?" Participants: Isabel Stamm, Moderator: Helen Hallinan, Elizabeth Kempton, Roslyn McDonald, and Irving Spergel.

[6] "The Place of Mental Health Clinics in Settlements and Neighborhood Houses" (New York: Mental Health Committee of United Neighborhood Houses, 1955). (Mimeographed.)

to fly into a vituperative tantrum if crossed by such authority figures as schoolteachers or welfare investigators. While her reality testing seemed adequate in that the slights, fights, and other situations that brought on the tantrums were real enough, her reactions to them were primitive and out of proportion. On the other hand, when her rage subsided, Mrs. A was left feeling depressed, hopeless, and alone. Tears flowed freely at such times.

Two things stood out in her relationships with her children. First, Mrs. A expressed great concern lest the boy become a homosexual ("I believe I'd kill me and him both if he went that way"), yet in her daily handling of him she was most emasculating and destructive of his self-esteem. A small but typical example occurred when the boy's class went to a museum and he bought some postcards to remind him of the exhibits he had liked. Mrs. A upbraided him for spending his money so foolishly, yet she often complained that he showed little interest in anything and was concerned that he get a good education.

The second striking thing about Mrs. A's relationships with her children was her drawing of succor from them rather than they from her. In the background of an especially tearful telephone interview the worker could hear a soothing 3-year-old voice, "Don't cry, Mama, don't cry." Mrs. A's infantile self-involvement caused her to see her children's illnesses more in terms of her own pain and suffering than of theirs. "I just can't take no more! All this whining and hanging on to me."

Mrs. A's strengths included her intelligence and her stated desire for financial independence. A report from her hospital clinic revealed that Mrs. A should be able to work a normal amount and that many of her symptoms were emotionally based.

Mrs. A had been a client of one of the large, city-wide family agencies before she came to us, but had broken off treatment. She felt that the worker was "never there when I needed her." The agency reported that Mrs. A was unable to see her own part in her problems, projecting it on to others.

The importance of proximity and availability are illustrated in the A case:

> Worker took his cue from Mrs. A's statement that her previous worker had never been available when she needed her. He saw Mrs. A as relating to the worker on a "demand schedule" reflecting her infantile, dependent personality structure. He felt that in order to start where this client was, he must be available to Mrs. A whenever she cried out for his nurturing. This led to a most uneven contact. Rarely did Mrs. A come when the worker expected her. She might come twice in one week, then not see the worker for a month or two, then resume contact again. The worker was also available to Mrs. A for long telephone interviews. He gave to her in such tangible forms as small emergency loans and by making telephone calls for her. Despite the unevenness in this contact and the fact that it was difficult to discuss problems with Mrs. A when she was not facing a crisis, the worker's availability at times of crisis made him a meaningful person in this client's life, one she really felt was there for her, not only on his terms, but on hers as well.

This relationship was used over the course of several years toward a slow but steady improvement in this situation.

The A case also shows how the different services can be brought to bear in treating a family. It will be recalled that Mrs. A first applied for nursery care for one of her girls and then was referred for casework help.

> During the course of treatment, another of the girls was accepted at the nursery and the first girl graduated to the school-age day care program. In these settings the girls were away from Mrs. A in a more wholesome and stimulating environment than Mrs. A with all her tantrums, crying jags, and self-involvement could provide. Having them away for a good part of the day gave Mrs.

A time to get hold of herself and enabled her to give more of herself to them when they returned in the evening.

We were concerned about the boy in this family. Mrs. A was worried that he was effeminate in many ways. We felt that in the group work program the boy could be observed by a professional person who would give us a more objective picture than his mother could. Also, in a group of boys his age and with a male adult leader, the boy would have opportunity for masculine identification not available to him in his overwhelmingly feminine family. A summer camp program was also arranged for the boy.

At Christmas we were able to give Mrs. A some toys to give the children, and some groceries. This may seem old-fashioned as a treatment technique, but it meant a great deal to Mrs. A.

Mrs. A soon began to see the worker as the person to whom to turn in distress. At first, she would call on the worker after having had a tantrum in the office of the school principal, housing manager, or other authority person. Together, the worker and Mrs. A took a realistic look at the incident, putting into proper perspective whatever insult, slight, or improper service had infuriated Mrs. A. After a while Mrs. A began to call the worker before having the tantrum, thereby heading it off. This happened time after time until the worker realized that Mrs. A was calling in a rage less and less often. Several times she described potentially explosive incidents that she had handled herself in much the same way that they might have been handled by herself and the worker together.

A similar method was attempted in helping Mrs. A to deal less destructively with her son and in various other areas of her day-to-day life. It is still too early to tell whether there will be, in Hollis' words, substantial "modification in adaptive patterns" in this case (see below), but at this time Mrs. A seems much more hopeful for the future and better able to handle frustrating situations.

THE B FAMILY

With some clients contact is briefer (though help received may lead to their returning in subsequent crises). The B's are a young Puerto Rican family.

Mr. B, 21 years of age, married Mrs. B, 25 years old, after their three children were already born. They came to the center for help after Mr. B lost his job and they were completely without food or money, awaiting completion of a Department of Welfare investigation. Mrs. B became the principal client and revealed a history of great deprivation, including the losses in early childhood of a mother, a mother substitute, and her father. She was then passed from family to family, finally coming to New York as part ward of, part servant to, another family. She married her husband because he was kind to her. "He gave me things."

Mrs. B struck us as most primitive, not only in her personality and ego development, but also in her cultural outlook. Her attitudes toward religion, health, and even death reflected the peasant culture from which she came.

When we moved into the case, Mrs. B was feeling most hopeless. She had no friends, could not communicate with her husband, was thinking of destroying herself and the babies.

In the B case, illness, the demands of caring for three small children, and the lack of concern of the B's for time made it impossible to see these clients through office interviews. The worker visited the home often, and this show of interest and concern made a real impression upon the deprived, dependent Mrs. B and led to her being ready to take specific direction from the worker in a time of crisis.

We began at a point where the family had no food or medicine for a sick baby and were awaiting action on their application to the Department of Welfare. A call to that department revealed that the B's had misunderstood something and that help might be further off than they

thought. A small loan was given to the B's and a Spanish-speaking worker was assigned to the case, visiting the family in its home. In her despair, Mrs. B clung to the worker, telling her unhappy life story. Through this Mrs. B gained some support, and the worker gained an understanding of Mrs. B's needs. A real crisis arose when it was learned that the reason welfare help was so slow in coming was that Mrs. B was defying the Department of Welfare, noisily and angrily refusing to bring them certain information needed to complete their investigation. Then the worker took on the role of the firm mother that Mrs. B was so obviously seeking and told her decisively, "You have no choice. You must go to see your investigator." The histrionics ended abruptly and Mrs. B followed the worker's direction. With the help of the Department of Welfare the situation improved. In subsequent interviews Mrs. B had no problems to discuss with the worker but spoke freely about how much her relationship with the worker had meant to her.

Few other types of settings could offer such a broad treatment plan to a family. Both families described above were helped by the caseworker at the community center —while Mrs. A's case had been quickly closed by a larger, more formal family agency, the B's were unlikely ever to have reached such an agency.

CASEWORK TREATMENT

The first step in casework treatment is the establishment of a relationship with the client which means enough to him for the worker to have an impact upon him. Reiner and Kaufman see this as the first and most difficult of their four stages of treatment of clients with character disorders.[7]

The infantile and dependent clients under discussion spread their dependency around them wherever they go. They run in panic from one person to another and from agency to agency, either draining the first person completely before moving on or arousing rejection from him. In trying to establish a working relationship with such a client, we must first make ourselves the focus of at least a good part of his dependency—the person to whom the client runs in his panic, not just once, but habitually. He must be "hooked." If dependency is his way of relating, let the client be dependent upon the caseworker rather than a dozen other people. Then, at least, we have him to work with. To achieve this we must start where the client is.

In starting where a particular client is we must be ready to perform such tangible services as making a telephone call for him, lending or giving a few dollars, making out a housing application, giving discarded clothes, and so on. Some of these services may be demanded in the most hostile, dictatorial manner. However, the demands must be seen for what they really are: those of a helpless infant seeking comfort. The manner in which such contact is made is illustrated in the case of Mrs. A described above.

Once some contact is established with the client, then treatment proceeds along the lines of what Florence Hollis describes as "Type I treatment," embracing "a wide range of treatment processes including environmental manipulation, immediate or direct influence, and logical (or reflective) consideration of reality and manifest behavior." She considers this

> the treatment of *preference* when the client's problem is not one that rests upon a substantial degree of neurotic distortion of behavior, or when the client does not want help with neurotic behavior patterns even when they exist, or when the degree of disturbance is so great that the ego might not be able to deal constructively with tensions involved in gaining understanding of sup-

[7] Reiner and Kaufman, *Character Disorders in Parents of Delinquents, op. cit.*, p. 67.

> pressed or uncomprehended mental content [emphasis the author's].[8]

Miss Hollis feels that this type of treatment can often lead to real modification in adaptive patterns. At other times it may lead to improvement in functioning without such a basic change, and at still other times may help a client through a crisis period with a minimum of regression.[9]

Two other paragraphs in Miss Hollis' paper effectively describe casework with these clients.

> By the ego's very nature, its contact with external reality, it uses later life experiences to enable it to control harmful impulses and to combat irrational and inappropriate responses motivated by the unconscious part of the mind. Cannot reality itself therefore be used as a corrective in modifying ego patterns if a person is helped repeatedly to look at external reality and examine and re-evaluate the evidence for some of his misconceptions and the results of some of his ways of functioning?
>
> Another method depends primarily upon the use of the relationship to the worker. When the client responds to the worker as to a good parent it is not infrequently possible to induce him to try new ways of responding or take on new attitudes on the basis of his confidence in the worker. . . .[10]

As illustrated in the B case, there is no "modification in adaptive patterns"; there is help over a specific crisis. As is so often the case with people whose ego functioning is primitive, Mrs. B reacts completely to the immediate. When danger or pain is imminent she seeks help desperately, but when the crisis is past, she is not ready to sit down to look inside herself to see why it is that she gets into such situations. She wants to continue the relationship that has meant so much to her, but on a personal friendship rather than client-to-worker basis. The type of help received by Mrs. B may be temporary, but in this case it may have saved the life of a sick infant.

Reiner and Kaufman found that after a long period of treatment many of their clients had "worked through [their] pre-oedipal fixations with relative success." This enabled worker and client to enter their fourth stage of treatment, in which "the caseworker's aim is to help the client gain some understanding of his behavior and its roots in the past."[11] Our experience was not extensive enough to reach such a stage with many clients. This level of treatment may prove to be rare with such families, yet help short of this goal may be quite profound.

CONCLUSION

To summarize: the aim of this paper is to show that the worker in the settlement house or community center can often make some constructive impact on clients who are largely inaccessible to workers in other settings. Many of these clients can be considered "hard-to-reach," and the help to them may be slow, temporary, and undramatic. Nevertheless, through the fact that the setting is local and informal, and through emphasis on the resources of the center in the application of casework techniques, many such clients are helped. These are not new ideas in social work. They are as old as the settlement house movement. Yet as casework skills became more refined, casework agencies consolidated and left the neighborhood. The settlement house gives us a chance to bring these skills back to grimy, noisy, brick-hard, vital neighborhood life. Joined with other disciplines and services, caseworkers may begin to reach the group of clients that most need reaching.

[8] Florence Hollis, "Analysis of Two Casework Treatment Approaches," p. 16. Paper delivered at the biennial meeting of the Family Service Association of America, Cincinnati, Ohio, November 17, 1956. (Mimeographed.) A revision of this paper will be published in the *Smith College Studies*, spring 1961.

[9] *Ibid.*, p. 3.

[10] *Ibid.*, pp. 7–8.

[11] Reiner and Kaufman, *Character Disorders in Parents of Delinquents, op. cit.*, p. 140.

BY JANE H. PFOUTS

Laughter as an Element in the Casework Relationship

ALL OF US, because we are human, laugh, and to each of us nothing is more sacred than what we optimistically refer to as our sense of humor. A man will admit to almost any crime except that of being deficient in a sense of humor. We laugh at all manner of things in all manner of situations and no one has yet been able to tell us why, although considerable sober thought has been given to the question by philosophers, psychologists, and laymen since man first became conscious of himself. This paper will not attempt to discusss the many and divergent nonpsychiatric opinions as to why men laugh, nor the role of the unconscious in laughter as first delineated by Freud and developed by Bergler and others of psychoanalytic persuasion.[1] Sociologists have shown some interest in the specifically social functions of laughter in such structured situations as interdisciplinary staff meetings in a psychiatric setting.[2] It is important that social workers be aware of these theoretical contributions by other disciplines, but they should also look at the significance of laughter, not as psychiatrists or philosophers or sociologists, but as caseworkers. Surprisingly, this is a subject virtually ignored in social work literature.

In this paper an attempt will be made to describe some of the ways, both constructive and destructive, in which laughter is used by client and worker in the casework relationship; also to show that the worker can understand and work with laughter as it occurs in casework only as she understands the relationship between the client and herself at the time laughter appears.

If we grant that the primary function of the caseworker is the giving of help on a psychological level, it follows that we cannot help unless we become aware of and responsive to the immediate emotional life of the client. Laughter is one facet of that life. In the laughter of the individual one can find a clue to the essence of the person, even as one knows him better when one sees what makes him cry and what moves him to anger. Thomas Carlyle goes so far as to say, "Laughter is the cipher-key wherein we decipher the whole man." As a caseworker, speaking without literary license, one would not state it so strongly, but in casework laughter is in-

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[1] Edmond Bergler, *Laughter and the Sense of Humor* (New York: Intercontinental Medical Books Corp., 1956); Sigmund Freud, "Wit and Its Relation to the Unconscious," in *The Basic Writings of Sigmund Freud* (New York: Modern Library, 1938); Sigmund Freud, "Humour," *Collected Papers* (London: Hogarth Press, 1950), Vol. 5, pp. 215–221; Martin Grotjahn, *Beyond Laughter* (New York: McGraw-Hill Book Company, 1957).

[2] Rose Laub Coser, "Laughter Among Colleagues: A Study of the Social Functions of Humor Among the Staff of a Mental Hospital," *Psychiatry*, Vol. 23, No. 1 (February 1960), pp. 81–95; Anne T. Goodrich, Jules Henry, and D. Wells Goodrich, "Laughter in Psychiatric Staff Conferences: A Sociopsychiatric Analysis," *American Journal of Orthopsychiatry*, Vol. 24, No. 1 (January 1954), pp. 175–184.

deed significant—not as a frivolous diversion from the casework relationship but as one element of the relationship itself.

No one can question the fact that laughter is deeply and primarily social. It is in relationship that laughter is characteristically found, and it may therefore be expected that casework, in spite of the essential sobriety of its purpose, will not be without it. The use a client makes of laughter reveals much of what he is feeling at the moment, for like tears, like anger, like all our emotional life, it is fundamentally a quality of feeling—not of thought—and rises unbidden from sources beyond conscious control. This is also true of the caseworker as he relates to the client.

In discussing laughter, one will probably succeed in making this most lively of subjects quite dull. This is unavoidable, since the essence of laughter defies examination. One can only yield to and enjoy this most temperamental of mistresses. Let anyone approach her critically or appraisingly and she is gone, leaving behind an arid collection of words to examine. This is by way of warning to the reader who does not realize that a paper on laughter is likely to be rather lacking in that commodity!

The following illustrations come from the writer's experience as a student caseworker in both a prison and a hospital setting. Surely neither place would be considered fertile ground for laughter, and yet it was there, flourishing in the midst of sickness, imprisonment, and death.

As a beginning caseworker one felt guilty in responding to humor offered by the client, and guiltier yet in initiating it. However, in spite of stern resolve, moments of laughter continued somehow to creep in, often when least expected. Eventually, in self-defense, one began to examine these regrettable lapses more closely to try to determine why they occurred and what they meant to the casework relationship. The writer is now convinced that laughter occurs in casework more frequently than case recordings would indicate, and is detrimental only if the worker fails to understand it and deal with it appropriately. Equally important, the worker must understand something of his own use of this most seductive of emotional reactions so as not to use it unknowingly to meet his own needs rather than those of the client.

Laughter is the great equalizer. In the moment of shared laughter, worker and client tacitly acknowledge the essential human sameness underlying their assigned role differences. Herein lies its power in casework whether for good or evil. Used appropriately, it can strengthen and illuminate relationship; used inappropriately, it can defeat and destroy it.

UNEASE IN A NEW SITUATION

When the client first comes to the agency, he brings with him the knowledge that he has a problem beyond his control to solve alone. Thus he carries with him the guilt of failure and the fear that this unknown agency will see him as a person without worth—even as he may see himself. In addition, he has the fear that the agency cannot or will not help him. How does he arm himself in his position of weakness to present himself to the worker? It is likely that, in addition to formulating a more or less ego-protecting version of his problem, he will make a determined effort to contain his fear in some way and to maintain his dignity before this stranger to whom he must admit inadequacy. In the tension of this all-important first meeting with the worker he may handle himself in various ways. He may be guarded and reticent, hostile and belligerent, tearful and dependent, or, quite unexpectedly, jolly and offhand.

We have all had the experience of finding ourselves in a strange and stressful situation and attempting to see it through by means of the pointless smile, the ingratiating laugh, or the nervous giggle. Surely this is the least humorous of re-

actions and one that horrifies us even as we continue to use it, revealing to everyone present, we are sure, our deep unease and feverish desire to be accepted in this alarming new situation. If one has ever lived through this travesty of good fellowship (and who has not?), he should be able to feel with the client in the new situation that may have almost life-and-death implications for him. To the worker able to hear, the laughter of the jolly new client may well carry an anguished message: "I need you—but I am still worthy of your respect. Like me and help me—but don't pity me."

This laughter is mainly a spontaneous tension-reducing device. In addition to this, however, it may be a reaching out toward union, a willed act to coerce or control through personal friendship or, paradoxically, a device to maintain distance rather than diminish it.

The worker may have some of the same sorts of problems. He may feel some unease himself in this new situation and react with discomfort to the discomfort of the client or to the type of problem presented. He may have a deep need to be liked, or may be unable to endure silence as the client attempts to find himself in the relationship. Because of any of these things, the worker may feel impelled to take the easy way out by initiating a jovial exchange or by responding lightly in order to make of the situation something not painful but rather social and pleasant.

Responding to the fact of laughter or to the content that accompanies it rather than to its meaning in relationship may momentarily ease both client and worker, but it will also encourage the client to be less than honest with himself and with the worker. It will set a mood of falseness and will trap the client in a role through which he cannot reveal the self he must reveal if he is to change and grow. The client may treat the situation inappropriately out of his deep fear of revealing himself, but the worker has no such excuse; it is his responsibility as a professional helping person to show the respect for the client and his problem that both deserve. The specific response of a caseworker to laughter depends, of course, on the specific way the client has chosen to use it. Hopefully, the worker, by both verbal and nonverbal means, will convey his awareness of the existence of needs in the client beyond laughter and his willingness to attempt to understand them. He should also be aware of his own personal needs in order to guard against initiating or responding to laughter selfishly, either to avoid facing the pain of another or to enhance his own ego by showing himself as clever and amusing.

The writer's first interview with a prison client is illustrative of a client's use of laughter in the beginning of a relationship. There was a chapter of Alcoholics Anonymous in the prison, and it was decided that the social workers should interview all those who signed up for membership to make sure that each was a serious candidate and not merely attending for diversion. When this particular applicant came to the office, she treated the whole matter as hilarious. "I just want to go for kicks," she said, laughing loudly and emptily. "Drinking never did bother me any, but it would be fun to see what happens in those meetings."

This attractive young woman from a respected small town family had lost husband, children, reputation, and freedom because she was an alcoholic. Yet she sat in the office, haunted and tragic, shaking with "nerves," and laughing her denial of need for the help she had sought. In situations like this the worker must be able to respond with sensitivity—not to the flippant attitude, so inappropriate to the reality situation, but to the pain, guilt, and longing to be respected that lie behind it.

In this particular case, the writer was able to stem her immediate hostile impulse either to challenge the laughter or to give

a little speech on the importance of motivation for membership in Alcoholics Anonymous. Instead, she attempted to convey, nondefensively, her awareness of how difficult it must be to bring a request for this help to a stranger but how good it was that she was able to do so. The client responded to this soberly and without laughter and began haltingly to say the things she had come to say.

PROJECTION OF MASKED HOSTILITY

Another type of laughter that sometimes occurs in the early stages of casework is a projection of disguised hostility. The content that masks it is the "half-joke, whole earnest" sort of thing. As social workers, we know the importance of recognizing the negative, and certainly if we are really listening to the client we find it not only in overt statements but creeping into the conference in all manner of disguises. A worker has too much power over the client for any but the most impassioned or reckless to say bluntly that he does not care for the agency, the policies, or the worker. Yet we know that in the helping situation he cannot escape some degree of negativism. One of the ways in which the client is likely to handle this feeling is through the hostile laughter of sarcasm or derision. This aggression is usually not presented as a direct assault on present company, but displaced on another social worker or social agency disguised in the cheerful raiment of a "good joke." Since it is often very difficult for the worker as well as the client to acknowledge negative feelings, it is a great temptation, basking in the sunny atmosphere of superficially jolly rapport, to let this opportunity to explore the negative go, or even neglect to recognize it at all.

Clients will attempt this negative bathed-in-sunshine approach through witty stories about stupid social workers and muddled agencies they have known—in contrast, of course, to the present worker's rather exceptional qualities of intellect and organization. Being quite drawn to this description of herself, and having the well-known preference for a pleasant situation over a painful one, the writer was a long time coming to the reluctant understanding that what the client was really saying about the worker and the service was not nearly as flattering and full of good will as the worker preferred to assume. When the client feels enough need to reduce hostile tension to use this means, the hostility is usually very near the surface and accessible to examination. If a worker can accept such a sign of covert hostility for what it is and allow himself to go into its implications with the client, movement toward a more positive and fruitful relationship becomes possible.

The types of laughter mentioned above tend to appear in the early stages of the relationship. The client is trying to connect himself to the worker and to the help offered, and the worker is reacting to the struggle of the client to clarify for himself what this relationship is to be. The client, attempting to gain some mastery of his own feelings and of the situation, is projecting humor on this unknown quantity, the worker, from what he hopes is a well-fortified position. The laughter may be a propaganda leaflet urging understanding and the special considerations of friendship. It may be a smoke screen to hide or distort the problem or treat it as if it were of little consequence. It may be a poisoned arrow of hostility aimed at the heart. Perhaps it is fundamentally a misplaced expression of ego strength in which the client is saying, as Lincoln once said: "I laugh because I must not cry—that's all, that's all."

HYSTERICAL LAUGHTER

Another type of laughter which may appear at any time in the relationship occurs occasionally at points of crisis. This is when

laughter is a final sort of emotional reaction like bursting into tears. Things get so bad and the client feels so horrible that suddenly the whole thing is funny in an insane sort of way. As Thurber says, "Perhaps the hysterical laugh in the face of the Awful is the rockbottom of humor."

Such laughter certainly can and does appear in casework and is often very relieving to the client as a means of tension reduction in a desperately tragic situation. Here the client is not using laughter to defend himself against the worker or to unite with him. He is using it spontaneously to save his own sanity. The worker who because of his own needs joins the client in hysteria over the fact that, right after the family was evicted, Father had a heart attack and Junior was run over, will find the client rightly angry and resentful that the worker dared to make light of his tragic situation. This points up the great danger of the worker seizing upon the laughter of the client to meet his own needs. The skilled worker recognizes his own needs and contains them and will then be able to respond appropriately to the feeling of the client who needs emotional recognition so desperately.

A happier example is the hysterical laughter that comes as a release after crisis. It is closely related to laughter in the face of the Awful in that it is a spontaneous reaction to a reprieve from the Awful. Most medical social workers have seen this, for in the hospital setting life scores many an unexpected and dramatic victory over death, and between one moment and the next a patient or his family can hear the good news that changes defeat into victory.

In one case the writer sat with a mother for two hours while her little boy underwent a critical operation he was not expected to survive. The suffering of the mother was, naturally, intense. Finally the doctor came out of the operating room and told her that her child would live. She sat paralyzed for a few moments after he had left us and then began to laugh hysterically. She managed to gasp an explanation. "Did you notice the doctor? He had one blue sock and one brown one." This was followed by more laughter. Finally the client wiped her eyes and said, "I feel much better now." And so, indeed, did the worker!

In this case, the content was merely a chance vehicle to carry the flood of emotion that demanded release. Anything else within this mother's immediate field of perception could have triggered off the same reaction. Because she needed to laugh, she found something to laugh about.

It is fortunate that nature has provided such a safety valve to handle the sudden release of almost unbearable tension. It is also fortunate in casework if the worker can look behind what is, on the surface, an unseemly or wildly inappropriate response to something generally conceded to be "no laughing matter," to the need of the client that has led him to use it.

Like the client, and for the same reasons, the worker also occasionally feels moved to hysterical laughter at most unexpected and inappropriate times in casework. Unfortunately, this unseemly impulse may be almost as overwhelming as it is unacceptable to the worker's supergo. Unless the situation is one of unqualified joy and relief for the client and unless the laughter is initiated by the client, as in the case of the doctor and the socks, the worker cannot permit himself this relief. A worker need not feel guilty simply because he has such an impulse to laugh inappropriately, but he does have a professional obligation to contain it and also to help the client feel less guilty when he has not contained it.

INSIGHT AND IRONY

There is one phase in casework during which laughter is, in this writer's experience, very seldom used. This is the crucial period during which the client begins to drop his defenses and becomes really com-

mitted to treatment. When he is able to find the courage to engage in a process of self-examination, he is far too subjectively involved in his own painful introspection to be able to achieve the spontaneous shift of perspective necessary to laughter. It is only when he has come to some sort of terms with himself and the situation—only when he has achieved a degree of mastery over his pain through acceptance of it—that he may again be able to feel humor and express it. Laughter cannot occur until the pain is receding or under control. When this moment comes, the client who has until now been locked in his own subjective problem may suddenly become able to mobilize himself to stand aside from it for a moment and see himself as a part of the human comedy. The resultant laughter reduces tension and releases energy in the same way tears or anger would have done if he had used them instead, and the momentary respite gives him new courage to face what he now understands must be accepted and faced. Through laughter he is able to bear a moment of truth and gain the strength to live with it.

This use of laughter as a restorative is one with which we are all familiar in our own emotional lives and one that has been noted, gratefully, by men throughout the ages. Heine, the great German poet and playwright, says:

> And when the heart in the body is torn,
> Torn and bleeding and broken,
> We still have laughter, beautiful and shrill.

And Mark Twain, a master expositor of tragic humor, has said, "Everything human is pathetic. The secret source of humor itself is not joy but sorrow. There is no humor in heaven."

Certainly, in the laughter that follows a moment of insight in casework there are intermingled elements of joy at coming to terms with oneself and sorrow at the sight of that which one must accept as the reality of the self. Perhaps a few illustrations will make clearer what is meant.

One of the writer's clients in the hospital was a woman who blamed her husband, her mother, the local welfare authorities, and the neighbors because her child was desperately ill as a result of malnutrition and general neglect. Finally in casework she came to accept her own very real and central responsibility. In the crucial interview when this happened, she suddenly said, "I can see now that it really is my fault and no one else's. I am the mother and I could have made it different." She cried quietly for a few moments and then, unexpectedly, began to chuckle with real amusement. She explained her laughter, quite embarrassed by its untimely appearance. "I must be crazy to laugh at a time like this, but I suddenly had a picture of that poor social worker's face when I said, 'I hope you're satisfied now that you've put the baby in the hospital.' "

It is perhaps possible to detect elements of negativism and hostility toward the "poor social worker" in this incident, but the more dominant fact is that this client had achieved a much clearer picture of her position in regard to others than she had before. Her recognition of the ludicrous aspect of her previous position was a playful affirmation of an essentially painful insight.

Not dissimilar in spirit was the reaction of a client who was in prison serving the first year of a long sentence for murder. This young woman had a hard time accepting the fact of imprisonment and her own responsibility for it. She was able, over time, to work through this to the point where she could claim both her crime and its consequence. Facing the fact of her own guilt was a very painful and difficult process, but once she had done so, she drew strength from such jokes as, "If the customers keep complaining about my cooking (she was a prison cook) I'm going to have to leave."

Because this inmate could see clearly and

without illusion a situation of her own making from which she could not escape, she found in laughter a momentary respite, not from reality but from pain. This client used patently absurd content in such a way as to convey to the worker the knowledge that she could face reality and live with it. Until she had arrived at some sort of emotional acceptance, she could not have used laughter in this way, nor would the worker have felt free to reply, as she did, with responsive laughter.

In contrast, laughter sometimes comes as a result of a realistic appraisal of the outside world and the unreasonable and irrational demands it has made on the individual. This is the laughter of pure tragedy, helpless bewildered laughter at the irony of fate—laughter that is the last-ditch defense of a self crushed by its own limitations in its environment.

One prison client, a middle-aged woman without skill or education, crippled with arthritis and the widowed mother of a large family, had been sentenced for making bootleg whisky. She frankly acknowledged her guilt, but laughed sadly as she said, "If I hadn't done it, the kids wouldn't have had enough to eat. Don't you see something ridiculous about a system where a person has to supplement her ADC check of $60 a month by making whisky? Everyone in the courtroom thought it was very funny and it was, in a way, but the joke's on me."

In this particular case the facts as she stated them appeared to be correct. Perhaps, limited as she was, she could have found some way out of her dilemma with some other worker, but during her casework relationship with the writer neither of us could arrive at any workable alternative to her antisocial solution to her problem. Unless her ADC check has been materially increased since her release, one would hazard a guess that she is back in business at the same old still. In this client's use of laughter she was able to convey, far more vividly than by tears or anger, her emotional relationship to the outside.

In this case, the client indicated to the worker her recognition that an objective situation had overwhelmed her. Joking about the irony of fate, if the client is realistic in his appraisal of the facts, is usually an indirect appeal for help in dealing with the environment. This client was not seeking to amuse the worker and would have been angry had the worker laughed. In this particular case, the client's use of laughter was the clue that turned the attention of the worker primarily toward verification of the external situation and attempts to modify it, and secondarily toward psychological change in the client.

THE LAUGHTER OF ENDING

As the casework relationship draws to a close and the client begins to move from his use of the worker to new use of himself, social laughter of a more conventional type may become frequent. The client begins to see the worker, now that the struggle has been resolved, as a friend to whom he owes much and toward whom he feels a warmth and closeness because of the experience they have shared and the help he has received. At this point the client may offer humor to the worker as a sign of friendship, or simply because the casework relationship has made him feel good. Sharing something that has amused him or merely indicating good will through a warm smile is very common as casework draws to a close. The worker, too, may feel this same warmth in regard to the client and is likely to initiate as well as respond to laughter.

When this point is reached, it seems a sure sign that the time for ending has come, and this should be recognized with the client. There is often a tendency for the client, faced with ending, to linger at the door as it were, reluctant to cut off what has been a meaningful experience and to leave the warmth and security of the case-

work relationship. The worker may feel the same reluctance, and one or both may cling through laughter to a relationship that is, in fact, already finished. The content that carries this ending laughter differs from earlier content in that it usually concerns matters far afield from the problem with which they have been concerned. What better indication could a worker have that the client has taken help and has assumed responsibility and control of his problem? If the laughter of ending can be recognized for what it is, it can be one last union that helps the client find additional strength to carry his old burdens in a new and more responsible way.

CONCLUSION

No aspect of casework is more challenging and elusive than the development of skill in recognizing and responding to the emotional interaction of the worker and the client in relationship. Unless there is communication on an emotional level, the client cannot be helped toward psychological growth, and casework in its true meaning cannot take place. The effort here has been to make the dynamics of this communication understandable to the reader by examining one element—laughter—an emotion largely ignored in casework literature.

Much more can and should be done with the subject of laughter. The hypotheses implicit in this paper are based on the subjective impressions of one worker. As such, they are of value only if they stimulate the interest of other workers in this area and are subjected to rigorous inspection in well-designed studies. Is not such attention long overdue?

BY ESTHER WHITE

The Body-Image Concept in Rehabilitating Severely Handicapped Patients

IN RECENT YEARS much emphasis has been placed on the need for conservation and restoration of human resources. All disciplines have taken up the challenge. As they have worked together, the concept of rehabilitation has broadened. It has become apparent that the individual's maximum restoration—physically, mentally, vocationally, and economically—is the end result all disciplines seek, though their individual contributions vary.

All who are concerned with the handicapped are aware that there are gaps and unknowns which retard our assurance of repetitive positive achievement. We are all familiar with the patient with severe physical involvement who makes a better adjustment than another with comparatively little involvement. To some extent this is explained by the observation that with severe illness there is generally emotional regression, and the degree of adjustment depends upon the individual's pre-illness personality. More recently the implication of the body image has been added. Each individual has an image of his own body. Owing to the physical impairment, the body of the patient with catastrophic illness usually undergoes considerable change. The recently disabled patient, however, continues to react to stimuli in accordance with his pre-illness concept of his body image. This understandably results in frustration and depression. Many articles have been written on the catastrophic results when the body image is damaged. Very little, however, has been written on what can be done to help restore the body image.

One article on a study of this aspect states that

> these experimental observations lend support to the theoretical significance generally assumed for the body image as a factor in an individual's adaptation to physical handicap. It would seem therefore, that the study of the individual's attitude toward his body image is a promising way of approaching the problem of disability. Meaningful relationships have been demonstrated between adjustment and the boundary aspect of body image. Perhaps it would be rewarding to extend investigation concerning physical handicap into other dimensions of the body concept.[1]

This paper will discuss the concept of the body image and consider how a better understanding of its implications has led to development of improved skills in the treatment of patients with catastrophic illness. The presentation is the result of six and a half years' experience with the Jack Martin Poliomyelitis Respirator and Rehabilitation Center of the Mount Sinai Hospital in New York City.[2] This unit, a

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[1] Kenneth E. Ware, Seymour Fisher, and Sidney Cleveland, "Body Image Boundaries and Adjustment to Poliomyelitis," *Journal of Abnormal and Social Psychology,* Vol. 55, No. 1 (July 1957), p. 93.

[2] Aided by an annual grant from the National Foundation.

facility for the care of poliomyelitis patients with respiratory difficulty, was established under joint auspices of Mount Sinai Hospital and the National Foundation in October 1953. Only patients who continued to have breathing inadequacy beyond the acute phase of the disease were admitted. No patient was denied admission because of the degree of paralysis or medical or social complications. Patients remained at the center from six months to a year.

At the end of this period some no longer needed artificial breathing assistance; a very small number were ambulatory. The great majority still needed the help of artificial breathing devices for two or more hours a day and remained wheel-chair patients with physical limitations in varying degrees of either upper, lower, or all four extremities.

To provide comprehensive medical care a treatment team of ten disciplines was brought together. The objective of this team was to return as many of these patients as possible to their homes and communities as functioning and productive citizens. To assure that gains made in the hospital would be maintained, strengthened, and even extended, a structured after-care program was maintained.

During the existence of the center, the social service department worked with 105 patients and their families. Out of this group only 9 patients were transferred to other facilities for chronic care. Ninety-six patients were discharged to their homes. Of the 9 who were transferred to other facilities for chronic care, only one demonstrated gross immature behavior to the extent of jeopardizing normal life and development for his wife and two young children. The other 8 patients were medically and psychologically ready and eager to return to their community, had there been an adequate home situation to receive them.

Of the 96 patients discharged home, one patient committed suicide. This patient's physical involvement was not as extensive as that of many of the other patients. His financial situation and his employment potential because of his pre-illness employment background, as well as his employer's continued interest in him, were much better than for many patients. Social history information indicated that, whereas catastrophic illness precipitated his action, it was likely that it might have occurred with other life stress as well.

The remaining 95 patients discharged to their homes and followed through the after-care program demonstrated good performance in spite of their severe involvement, including for a large number paralysis from the neck down. Many returned to former employment and some retrained vocationally to meet their new needs. In the few isolated situations where individuals were not remuneratively employed, they were functioning socially and were well integrated into family and community life.

ADMISSION

It will be appropriate here to discuss the patient and his family on admission and his life at the center. On admission the patient presents all the symptoms, or various combinations of symptoms, evidenced in other patients stricken with catastrophic illness: anxiety, guilt, inferiority, frustration, and depression. "This is expected in the recently disabled individual who must go through a 'mourning' period for his feeling of loss, whether it be of function, social status or employment." [3]

It is not uncommon that on admission to the center the patient's depression increases. This is true for several reasons. While in isolation during the acute phase, the individual is able to imagine many

[3] Samuel B. Kutash, *The Application of Therapeutic Procedures to the Disabled*, "Office of Vocational Rehabilitation Service Series," No. 343, (Washington, D. C.: U. S. Dept. of Health, Education, and Welfare, 1956), pp. 10–14.

things. He can minimize the seriousness of his illness and believe it is only of a temporary nature. Often there is the wishful and magical thinking that through some miracle his condition will change and he will, without change within himself, be able to pick up where he has left off. In preparation for his transition from the acute hospital to the center, he has been told about the center's specialization and all the modern developments in the field of rehabilitation. This only enhances for him and his family the fantasy that the advances of medicine will perform the miracle of complete recovery without difficult adjustment on their own part. On admission to the center, however, both patient and family for the first time realize that patients who have been at the center and on the center home care program are still severely involved. For the first time they recognize that there will not be complete recovery and that they, too, must invest themselves in making adjustments to meet their new situation.

With this recognition, depression and frustration frequently increase. In this there are positives also, since not until the miracle fantasy is dispelled can the patient come to grips with the reality of the situation and begin to relate with vigor and the necessary determination to the medical program. At this point, when the depression begins to diminish, we are better able to observe problem areas with which the patient is struggling and the help he needs to enable him to deal with them.

How to help him presents another problem. In the early stages of his illness the patient is virtually nonverbal in areas relating to the illness. This is understandably most frustrating to the social worker, since without verbalization he has only limited means for gaining insight into the patient's problems and needs.

In the hope that in a less formal environment the patient's defenses might be lowered and he might be enabled to speak more freely, short excursions in the hospital outside the center were initiated when he was physically ready for them. This did not change the quality of the patient's conversation. However, a marked change in demeanor and attitude was noticed by the medical director and other staff members in patients who had an experience away from the ward. It was on the basis of these observations that analysis of what this experience might be contributing to change was begun.

It was found that this nonverbal state is in itself related to the patient's new situation. For one, he is fearful of expressing himself negatively lest he antagonize those on whom he is so dependent. It is too frightening and threatening for the patient to hear himself say out loud what he fears most. It is only in retrospect and after he has made some adjustment to his new body image that he can, with some degree of comfort, talk about his painful experience and the difficulties he has had to face. Therefore the orthodox one-to-one interview in the early stages of his illness brings little result in uncovering his anxiety as a means of helping to diminish his strong need for denial. Obviously, then, before we can expect progress, other methods for helping the nonverbal patient to reconstruct his body image must be found. Whereas moving the patient off the center did not make him more verbal, there was a positive change in his general demeanor. Certainly this could be a possible beginning.

Dr. Grayson states that the disabled patient shows pressure from two directions. One is the reality pressure from the outside, which includes society's attitudes toward disablement and his family's pressure—social, economic, and vocational. The other is the internal pressure that centers around the disability in an attempt to find a place for his body image.[4] Certainly our

[4] Morris Grayson, M.D., "Concept of Acceptance in Physical Rehabilitation," *Journal of the American Medical Association*, Vol. 145, No. 9 (March 24, 1951), pp. 893–896.

experience confirms Dr. Grayson's conclusions. We have found that the patient must first be able to accept himself before he can feel accepted by others. Otherwise he projects his own attitudes of nonacceptance onto others and shuts society away from himself. If the objective is to restore the patient to a community where he can feel accepting of himself and accepted by his society, might not the most effective approach be to test him out in a society where he is understood and accepted?

The patient care program that was developed revolved around this concept, utilizing the hospital and staff as a microcosm community. We believe this helped to reduce the patient's inner pressure and enabled him more quickly and independently to find a place for his body image and adjust to his new self, regaining his security while still in the hospital. This basic foundation, furthermore, prepared him for making a more effective and productive transition for meeting his family and community responsibilities.

The hospital, a community within itself, offers a wealth of resources. Here is the patient's first contact with the nonhandicapped, and much of what he observes here in attitudes of understanding and lack of understanding, acceptance or nonacceptance, is very much what he expects to find in the community to which he will be returning.

The hospital exclusive of the center is a very busy and active place with the hustle and bustle of people from all walks of life who, as in the community at large, have their own individual ideas and attitudes toward illness and handicap. There are the gift shop and the coffee shop. There are the hospital barber and the beautician. There are dental appointments and eye refraction appointments.

LIFE AT THE CENTER

In the center there are similarities to the conditions of normal life, and there are differences. Every effort is made to have the center resemble a "coeducational residence" rather than a hospital ward. In this flexible environment tailored to meet individual needs, the patient is permitted to function with maximum freedom.

As in the hospital community and the community at large, the center staff is made up of individuals with their individual personalities who come from all walks of life and from all races, nations, and classes. The relationship between patient and staff, however, is different. Because of the patient's extreme dependency, particularly in the early stages of his illness, most of his physical needs are directly, and his emotional needs indirectly, met by staff personnel. For this reason staff members take on different meanings for the patient. In these relationships obvious transference and countertransference are observed. It is interesting that these identifications do not always apply to the doctor, psychiatrist, or social worker. It may be a nurse, therapist, or orderly. Because of the nature of the patient's needs these identifications cannot be controlled. Nor would it be wise or sound to control them even if it were possible.

Since the objective in rehabilitation is to prepare the patient for return to his community, where he must relate to many people and will need to choose and make his own relationships after discharge, it becomes obvious that we must permit him the same freedom here. In fact, the more positive relationships he has, the better is his prognosis for adjustment.

In addition to his need for freedom and self-determination, it must be recognized that the social worker can devote at most less than an hour a day to person-to-person relationship with the individual patient. The latter's remaining twenty-three hours he spends with other disciplines. This ratio of time makes it impossible for the social worker to achieve effective results without knowledge of what is happening the other twenty-three hours. Again the observations of the other disciplines in

their continuous daily living activities with the patient are extremely important for the social worker to know as a means of understanding the patient and his needs.

In essence it becomes clear that at the center the patient first begins to test out for himself—even if nonverbally—his new position as it relates to family and community. With testing out, there is acting out. Therefore it is with the center staff and its program that controls must be set for a warm, accepting, consistent environment where the patient can test out and act out without any feeling of loss of acceptance or status. To maintain this environment and assure consistent progress and treatment for the patient, there must be a continuous sharing of knowledge and observations between and among the disciplines. This must be done in order to meet the patient's ever changing needs, so that neither the patient nor his family become confused. We know that the feelings and attitudes of one react on the other. It is this environment with its subtle and meaningful identifications that permits the patient to regain his first assurance, security, and motivation for moving beyond the shelter of the center.

Although the patient is curious about what goes on outside the center, new experiences are anxiety-producing for him. Again there is the need to test himself and test out the reactions of others. In this struggle his feelings about his damaged ego and body image are reactivated. To verbalize these feelings is too painful. Withdrawal and denial seem easier than facing this difficult experience. But because he wishes to please those with whom he has established meaningful identifications, he is motivated to take this significant and important step.

Why is the patient's willingness to move out of the center's sheltered environment so important, even though emotionally he may not feel altogether ready? We believe that the center's climate and the hospital community lay the foundation for the patient's transition to the community at large and affect the quality of his adjustment to it.

In the effort to reach the nonverbal patient, we found that actively doing can be more productive than painful probing. What the patient finds as he moves out of the center may be much less traumatic than he anticipates. One excursion to the gift shop can answer so many painful questions for him: What is it like on the outside? Will people stare at him? Will he be able to tolerate this? What can the gift shop offer him anyhow in his present physical and emotional state? It is with much ambivalence that the patient agrees to this new adventure, and with considerable surprise that he discovers the resiliency of the human make-up and the strong drive he still has to recapture his pre-illness way of life. He does not notice people staring at him so much. He is too engrossed in his own observation of them and the activity all around him. He does not notice that the people in the gift shop, who unknown to him have already been prepared by the social worker, react to him any differently than to others. He hopes his relative will like the birthday gift he chose. He realizes that his new way of life is not going to be easy, but that all is not over.

Nevertheless, he accepts going to the coffee shop with similar apprehension. There will be many more unfamiliar faces in whose presence he must feed himself within his own limitations or be fed by the staff member who brings him. Again he has mixed feelings, but again the drive to recapture former human relations wins out. These repeated successful experiences give him new strength and stimulate him to attempt others. As he begins to see potentials for a new kind of independence, the patient becomes more relaxed and shows progress and growth in his daily living activities, physically and emotionally. His acceptance of self and of others is demonstrated in his increased interest in other patients and a different kind of in-

terest in staff and people in general. He has no need to verbalize his discomfort with his position of always having to take and not to give. He can now say to a staff member, "The next time we go to the coffee shop, it's my treat," and the staff member learns when this is appropriate.

Gradually he goes to the barber or beautician outside the hospital. This is extended to the movies, shopping, and a museum. The patient's family is delighted with the change in his appearance and his outlook on life.

THE FAMILY BECOME MORE ACTIVE

And now the family must become more active in their participation—in taking over the responsibility for the patient's future where it rightfully belongs. Space does not permit discussion of the dynamic implications of patient-family relationships when a member is stricken with catastrophic illness. It must be said, however, that unless the family members are immediately brought in on a continuous participating basis in all planning for the patient, they can very easily and even unconsciously begin to plan their own lives to the exclusion of the patient, and assuage their guilt by periodic visits and gift-bringing.

On the admission of the patient the members of the family are oriented by the social worker to the center's program. Of its many facets, one they must clearly understand is the need for patient-staff identification, so that they do not become disturbed by what may appear to them a conscious displacement of themselves by a staff member. It is not uncommon for family members to resent the hospital's taking over what they see as their responsibility—as displacement of their own relationship with the patient. This results in hostility and withdrawal from the staff, with unplanned hyperactivity to prove their importance to the patient, often creating innumerable problems for both patient and staff. When such attitudes are permitted to develop we no longer have access to, or utilization of, the many important roles the family must assume in all areas of planning.

Frequently the family are the first to face the reality of the situation and recognize the need for change. In these instances we are able to use our positive relationship with them by helping them to use themselves in constructive motivation of the patient. The results are gratifying in returning to both patient and family their feeling of usefulness to each other and their ability to achieve objectives together. With this there is a strengthening of security, unity, and independence.

Initially families are encouraged to visit consistently, to bring the patient food he likes from home, and to share with him family events and even problems. When the time is ripe the role is increased to taking over special aspects of the patient's daily living activity which in the beginning stages were a staff responsibility.

When the patient and his family are relaxed and able to deal with the first part of the program independently, discussion and preparation for the patient's going home for weekends is initiated. Both family and patient must feel ready to accept this additional responsibility. This requires several sessions with the social worker for supportive help and to evaluate reality needs. Information as to readiness is shared with the other disciplines.

The first weekend is always the most difficult, since both patient and family feel anxious and insecure. Immediately on return from the weekend both family and patient are again seen by the social worker and information is shared with other disciplines. Gradually this procedure also becomes a matter of routine, and the weekend is extended on special family or holiday occasions. In these weekends patient and family are encouraged to explore community shops, movies, restaurants, visiting, and so on. This dual process helps the

patient and his family to test their own capacities and at the same time offers the center the opportunity to make a more concrete assessment and evaluation of the patient's ability to function at home and in the community, and the readiness of his family to accept him. It is at this time that the survey for vocational objectives begins and the formulation for discharge planning is started.

Vocational objectives as well as a clear plan for carrying out these objectives must be started while the patient is still in the hospital where the necessary help, both supportive and in relation to reality needs, is available to him. Frequently they are completed after discharge, through the after-care program.

On discharge the patient and his family must have a clear understanding of their achievements: what has been accomplished and what has not been accomplished. They must be clear on what is expected of them and just as clear as to what they can expect from the center. Only with clarity of purpose and plan, and the knowledge that the treatment team will stand by, can they make the final and most difficult step of separating from the center. With this assurance, although the help offered may never be needed, both patient and family are enabled to build on the solid foundation laid during the hospital experience and move on to productivity and independence.

IMPLICATIONS FOR PRACTICE

Although this discussion deals with poliomyelitis patients, experience has shown that the same principles apply to other patient groups as well. With most catastrophic illness, there is physical impairment resulting in the need for long hospitalization and often for vocational reorientation. The anxieties and frustrations produced by the need for such extensive physical, emotional, and social realignment have been found to exist in most patients stricken with catastrophic illness. The need to relieve anxiety and frustration before an individual can be restored to productivity is a first priority wherever it exists. How frustration can be relieved and ways to offer sufficient motivation for productivity pose a problem.

Some of our conclusions are as follows. The patient with catastrophic illness, because of his extreme dependency and overwhelming anxiety, finds it difficult to verbalize. Continued experience shows that his nonverbal state is created by inner pressure produced by the struggle to find a new place for his body image and from outer pressure to find a place for the changed self in his pre-illness society. Since he is unable to verbalize his anxieties, other methods in addition to the one-to-one interview must be used, whereby he can for himself test out his strengths and the many potentials life still holds for him. Toward this end, utilizing hospital and staff as a microcosm community offers an effective method to help the patient deal with his reality and emotional needs for his restoration to normal living.

What happens to the patient reflects on the total family constellation. They, too, undergo severe trauma and need help in readjusting. To restore the patient for return to his family is not enough. The family equilibrium must also be restored to enable them to accept the patient before they can live together as a functioning and productive family unit. The family therefore must be brought in immediately and become part and parcel of the patient's progress and all his planning.

They must have immediate help with their anxiety, and assurance that we are as interested in them as in the patient. They must understand the program for the patient, as well as their own important role as it relates to the patient's progress. Without this consideration they can easily begin to feel that the patient is now altogether the hospital's responsibility.

Although every effort must be made to help the patient and his family to what

seems from experience the wisest choice, the final decision must rest with them. On first observation this may seem wasteful. Experience, however, has shown that there are times when the patient, and sometimes his family as well, must prove to themselves the impracticability of their decisions, since not until then can they relate positively to other proposals.

The severe physical involvement of the patient stricken with catastrophic illness demands that many disciplines become involved to meet his needs. Frequent communications between and among the individual disciplines is of first importance. Experience has shown that only through a close working, learning, and sharing relationship, with understanding and respect for the way each contributes toward the total whole, can productive results be achieved. The quality of the objectives achieved are only as sound as the links in the chain of the pooled energies of each discipline.

The treatment team is the first nonhandicapped group with whom the patient comes in contact. Because they must meet many of his physical dependency needs, these relationships take on various meanings for him. Much of what he observes here in attitudes and behavior is what he expects to find in the community at large. To maintain a consistent environment and program of treatment, all disciplines must understand this and learn to use themselves appropriately.

We have found that sound use of these relationships by staff, together with valid use of the hospital milieu as the patient's first community experience, constitute very effective means for laying a positive and solid foundation for his return to the larger community.

For the social worker working with patients on this service as well as on other services, casework knowledge and skills for evaluation and assessment of the patient and his family—for setting of goals and following through with social treatment—are basic. There are, however, differences from the usual casework practice. Because of the patient's dependency needs, staff relationships frequently take on for him identifications different from the usual. However, as long as these are to the benefit of the patient's growth and development, the social worker must know how to use them and himself productively through learning from, sharing with, and participating in the teaching of other disciplines.

Because of the social worker's special training and experience many aspects of the job become uniquely his responsibility. The social history constitutes the source of reference for evaluation of the patient's pre-illness situation and the basis of future planning for total staff. Working with the family in relation to reality and emotional needs created by the impact of the patient's illness becomes largely the social worker's responsibility also. Through the family relationship he deepens his understanding of the patient. This knowledge offers him better insight regarding the patient and helps to establish a more meaningful relationship with him. This relationship in turn enables the worker to learn of the patient's hopes and fears and gauge where he needs help and at what times he is best able to use it. When indicated, the social worker must become liaison between the patient and the doctor and at times with other disciplines. As the relationship develops he can help to motivate the patient not only for a better relatedness to the medical program and to his family, but toward vocational goals and return to the community.

Perhaps the greatest contribution made by the social worker to this particular situation is the way he used his professional knowledge to discover why these patients are nonverbal, to find methods other than the interview for dealing with this problem, and to convey this understanding to the other disciplines.

BY SHIRLEY A. REECE

Social Work Practice: An Exploratory Study

THIS PAPER REPORTS a piece of exploratory research conducted by members of the Social Work Practice Commission of the Golden Gate Chapter of the National Association of Social Workers.

Repeatedly and increasingly social workers are being urged to interest themselves in the study and refinement of their practice.[1] For some this is possible through participation in university or agency-based research projects; still other professional workers will pursue investigations on an individual basis. However, many workers, though well motivated, are diffident about undertaking an effort sound enough to be labeled research. It would seem, though, that within NASW there should be a substantial number of persons capable of taking part in less ambitious, yet potentially useful, research endeavors. Bearing in mind that research into social work practice can proceed from varying levels of sophistication depending upon the technical competence, interest, and financial resources of the investigators, the commission decided it would be possible to utilize the talents of its members to begin a very modest study of practice in the Golden Gate Chapter.

Regardless of the nature of the research planned, several basic questions arise to be answered: (1) What problem is posed for study and examination? (2) What information is necessary to illuminate the problem? (3) Where, when, how, and by whom can pertinent information be obtained? Such questions must be answered before one can hope to define and delimit the subject to be studied.

In our chapter, the commission was especially struck by two things: first, the sparseness of data about our membership with respect to employment, experience, education, salaries, and so on; and second, the complete lack of any objective data concerning aspects of practice about which NASW has considered formulating national policy. An obvious example of the latter was the series of proposed position statements presented for review by chapters and for discussion by the Delegate Assembly in 1958. Statements related to practice expressed the profession's concern that social workers are often oversupervised, that they spend too much time in indirect services, and that many practitioners are not sufficiently knowledgeable about all social work methods.[2]

Assuming that each statement had some basis in fact, we were prompted to ask: But what and where is the evidence? It need not be argued that, to the extent feasible, our professional association should be expected to have available or be able to produce valid and reliable data in support of

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[1] *See,* for example, Kurt Freudenthal, "The Why and How of Casework Research," *Social Casework,* Vol. 35, No. 7 (July 1954); Alfred J. Kahn, "Some Problems Facing Social Work Scholarship," *Social Work,* Vol. 2, No. 2 (April 1957); Harriett M. Bartlett, "Toward Clarification and Improvement of Social Work Practice," *Social Work,* Vol. 3, No. 2 (April 1958); Alfred Kadushin, "The Knowledge Base of Social Work," in Alfred J. Kahn, ed., *Issues in American Social Work* (New York: Columbia University Press, 1959).

[2] *Delegate Assembly Workbook 1* (New York: National Association of Social Workers, 1958), pp. 25–26.

any national policy statement. To be sure, there will always be exceptions, particularly in matters of social policy and action, where time and political considerations may preclude the slow and laborious process of research. However, in the area of social work practice there should be only rare instances when we are required to approve or reject a policy statement before we have had at least a look at whatever relevant facts can be assembled.

In the summer of 1958, the commission decided to begin a relatively uncomplicated study of selected areas of social work practice, and planned to do this by means of a mail questionnaire, potentially to involve a large number of chapter members in our project. Our goal was to gather information which would enable us to identify certain major characteristics of our membership and describe objectively something of the current content of their practice, particularly as it related to questions of national concern.[3]

We began construction of our questionnaire by having each member of the commission formulate a question concerning any aspect of practice which might be of general interest to NASW members. Beginning without preconceived ideas of where we should or should not center our attention, participation was encouraged and commission members allowed to be creative in developing questions. Later, each member was asked to write a rationale for his question—that is, to justify his reason for asking it, speculate about the kind of information his question might yield, and estimate the usefulness of such information to our local chapter, to NASW nationally, to social agencies, to schools of social work, and so on.

From an original group of eleven questions, four (relating to basic methods, supervision, interdisciplinary practice, and the use of time) were finally selected for inclusion in our questionnaire. These four questions, together with a face sheet, were rewritten and edited following discussion within the commission and with our research consultant.[4] The questionnaire was then pretested, using a randomly selected sample of our membership. Results of the pretest led to minor revisions, and in May 1959 the questionnaire was mailed to 710 full members of the Golden Gate Chapter. In addition, 70 members, randomly selected, were also sent a special Time Study Schedule to be filled out. Students and retired members were omitted, since we were interested only in the characteristics and practice of currently employed social workers.

In a covering letter, each member was asked to complete the questionnaire and return it anonymously within two weeks in a self-addressed stamped envelope, which we provided. Within three days more than 200 members had responded to the questionnaire. After our designated deadline of two weeks, a follow-up postal card was sent urging all members to respond. At the end of one month, when we closed our study, a total of 465 questionnaires, or 65 percent, had been returned—gratifying our most optimistic expectations. From our final tabulations we eliminated 25 questionnaires, returned by members who were either not employed or not currently working as social workers. To save money, but not time, all tabulations were done by hand and completed within three months.

Our findings are based on information furnished by 440 respondents, judged to be representative of our chapter membership in terms of geographical distribution and Section affiliation. Since it is not possible to say with certainty whether our sample is representative in other important dimensions, generalizations about the data should not be extended beyond our 440 respondents.

[3] *Ibid.*

[4] Henry S. Maas, Ph.D., professor, School of Social Welfare, University of California, Berkeley, and chairman, national Social Work Research Section, 1959–60, NASW.

INITIAL FINDINGS

Each respondent furnished the following information about himself: (1) the nature of his employment (full- or part-time), (2) the major method related to his present social work job, (3) the length of his full-time paid experience as a social worker, (4) his current annual gross salary, (5) the extent of his undergraduate and graduate education, (6) whether he engaged in any private practice of social work, (7) his Section affiliation, if any.

A simple tally of each item enabled us to describe our sample with respect to some major characteristics.

MAJOR CHARACTERISTICS OF 440 RESPONDENTS

	%
Were employed full-time	97
Indicated casework as their major method	50
Had 10 or more years of experience	64
Earned $6,000 or more annually	71
Had a master's degree in social work	84
Were engaged in some private practice	7
Without Section affiliation	45
Group Work Section	9
Psychiatric Social Work Section	23
Medical Social Work Section	15
School Social Work Section	6
Social Work Research Section	2

Because of space limitations, not all findings can be given in detail. Since we wished to highlight those items presumed to be of general and timely interest, we chose to present our data on salaries, cross-tabulated with education and experience and on social workers in private practice.

Clear in Table 1 (p. 62) is the fact that many members of the Golden Gate Chapter are a long way from achieving the NASW salary recommendation that, beginning with a base of $5,400, social workers should be able to look forward to receiving $10,000 annually after ten years of experience.[5] Almost two-thirds of our respondents had had ten or more years of full-time paid social work experience; yet at present less than one-fourth were earning more than $8,000 annually.

Other cross-tabulations of our data led to the conclusion that it pays, in terms of salary, to engage primarily in indirect services, in social work research, and in school social work. A large proportion of workers in each of these categories reported earning an annual salary of $8,000 or more.

Seven percent of our respondents, engaged in some private practice of social work, described themselves as follows:

30 RESPONDENTS ENGAGED IN PRIVATE PRACTICE

2 were employed full-time in private practice
16 indicated casework as their major method
24 had 10 or more years of experience
14 earned $8,000 or more annually on their job(s)
29 had a master's degree in social work
16 were members of the Psychiatric Social Work Section

This, then, is an experienced group of professionally educated social workers, with emphasis on casework as their major method and on psychiatric social work as their field of practice. Those concerned with the issue of licensing private practitioners may wish to compare our data with related findings elsewhere, in order to define in concrete terms the actual size of the problem. It should be emphasized, however, that we can make no statements about the nature, quality, or breadth of each worker's education and experience, which is perhaps essential in evaluating competence to practice independently.

We have condensed our summary of other findings, limiting this section of our report to selected questions and areas of practice which seemed to us most provocative and indicative of need for further study. For each question, as it appeared on the questionnaire, we shall give the rationale, some assumptions, our findings, and a brief analysis of them.[6]

[5] *Salaries: Official NASW Policy* (New York: National Association of Social Workers, 1959).

[6] Such terms as *group approaches, individual approaches, community organization, social work supervision, consultation, collaboration,* and so on were defined specifically in the questionnaire. These definitions are available from the author upon request.

TABLE 1. CROSS-TABULATION OF SALARY, EDUCATION, AND EXPERIENCE—440 FULL MEMBERS, GOLDEN GATE CHAPTER, NASW, MAY 1959

Annual Gross Salary	Members without a Master's Degree in Social Work				Members with a Master's Degree in Social Work					Total [a]
	Experience				Experience					
	Up to 2 Yrs.	2–5 Yrs.	5–10 Yrs.	10 Yrs. or More	Up to 2 Yrs.	2–5 Yrs.	5–10 Yrs.	10 Yrs. or More	Experience Not Indicated	
Under $4000		1	1			2	1	1		6
$4000–4999				3	10	4	4	2	1	24
$5000–5999			1	6	17	24	23	25		96
$6000–6999		1		13		12	35	66		127
$7000–7999				13		2	11	57		83
$8000 and Over			1	29 [b]			7	65		102
Salary Not Indicated							1	1		2
Total		2	3	64 [c]	27	44	82	217	1	440

[a] Includes 15 social workers employed part time.
[b] Includes 4 social workers with a Ph.D. degree.
[c] Includes 8 social workers without a B.A. degree.

BASIC METHODS OF SOCIAL WORK PRACTICE

QUESTION: *In your present position are you engaged in using group approaches (if you were trained as a caseworker) or individual approaches (if you were trained as a group worker)?*

Assumptions. Trends in current social work practice require that social workers use methods other than the one that is primary in their practice. Social workers should acquire knowledge of all social work methods and appreciation of the skills involved in the application of these methods, as well as particular knowledge of and skill in the application of a single method.[7]

Rationale. To test the assumption that social work practice currently requires social workers to use direct service methods other than the one that is primary in their practice, and to determine what preparation, if any, workers have had for such practice.

Findings. Forty-eight percent of those persons who responded to the question indicated that in their present position they were engaged in using a social work method other than the one in which they had had their primary training. Only 7 percent of the respondents had had supervised field work in more than one method, although nearly 100 percent (438 respondents) reported having theory classes in more than one method. In addition, there were 423 recorded instances of in-service training in casework, group work, or community organization.

Analysis. Our data would support the assumption that current social work practice requires that (a substantial number of) social workers use methods other than the one that is primary in their practice and for which they have had limited professional training.

[7] *Delegate Assembly Workbook 1, op. cit.*, p. 26.

If these data are assumed to reflect a trend toward more diversified practice, then schools of social work may need to find ways of modifying curricula in order to narrow the gap between the content of professional education and the requirements of present-day practice. This could pose a challenging assignment for social work educators, already faced with many pressures to expand the undergraduate curriculum and, at the same time, to enrich graduate programs to meet other new and increasing demands of the field. The problem, however, should not be sidestepped if we intend to maintain standards of practice which rest on soundly conceived and structured programs of professional education. Whether to leave to social agencies the responsibility of developing in-service training programs to finish the job of professional education is still another question, not within the scope of this paper.

SUPERVISION AND CONSULTATION

QUESTIONS: *Are you supervised by a social worker? (If yes) How frequently do you meet?*

Does your agency offer educational help or opportunity for professional development through planned resources of consultation (i.e., with other social workers or with members of other professions)?

Assumption. Supervision as an educational process has been maintained in many instances long after workers should have achieved the professional maturity necessary for continued growth without intensive supervision.[8]

Rationale. Social workers generally agree that professional supervision for training of students and for orientation of workers in new positions is useful, and that administrative review of practice is necessary to maintain and improve standards and to develop agency programs. Many social workers, however, question continuing the educational aspects of supervision beyond the time when a practitioner has achieved sufficient competence to take responsibility for planning and implementing his own professional development. What has been lacking, on a broad scale, is objective evidence of the amount of time given to supervision, the relation of this to experience and to salaries, and the extent to which agencies provide for other means of professional assistance, such as consultation, with job-related problems.

Findings. Fifty percent (222) of our respondents were supervised by a social worker, and of this group 45 were supervised two or more hours a week, irrespective of the extent of their professional training. The amount of social work supervision received, as related to length of experience and to salary, is summarized below (Tables 2 and 3).

Forty-nine percent of our respondents indicated that in their agency time for individual supervision decreased as workers gained experience, while others reported that supervision varied with individual supervisors and workers, or that individual supervision continued about the same for all workers (9 percent). Seventy respondents (16 percent) thought their agency had "no clear policy" in regard to supervision.

Eighty-one percent of our respondents reported that their agency offered educational help or opportunity for professional development through planned resources of consultation. A percentage comparison of the types of supervision received and types

TABLE 2. AMOUNT OF SOCIAL WORK SUPERVISION AND LENGTH OF EXPERIENCE

Length of Experience	Percentage of Workers Supervised 2 or More Hours a Week N = 45	Percentage of Workers Supervised Less than 2 Hours a Week N = 177
Up to but not yet 5 years	44	22
5 or more years	56	78
	100	100

[8] *Ibid.*, p. 25.

TABLE 3. AMOUNT OF SOCIAL WORK SUPERVISION AND ANNUAL GROSS SALARY

Annual Gross Salary	Percentage of Workers Supervised 2 or More Hours a Week N = 45	Percentage of Workers Supervised Less than 2 Hours a Week N = 177
Under $6000	62	38
Over $6000	38	62
	100	100

TABLE 4. PERCENTAGE COMPARISON OF TYPES OF SUPERVISION RECEIVED AND TYPES OF CONSULTATION OFFERED *

	Workers Supervised by a Social Worker	Workers Not Supervised by a Social Worker
Consultation with Other Social Workers	45	46
Consultation with Other Professions	81	76

* Percentage totals do not equal 100 because consultation categories are not mutually exclusive.

of consultation offered is given in Table 4.

Analysis. A relatively small group of workers (45), engaged in casework primarily (73 percent), were supervised two or more hours a week by a social worker. If we assume that supervisory time of two or more hours a week does not constitute "oversupervision" for the less experienced and less highly paid practitioner, it is then possible to conclude that social workers who responded to our questionnaire, in general, are not "oversupervised." The trend, as shown in Tables 2 and 3, is definitely to decrease the amount of supervision as workers gain experience and increase their salaries. At the same time, regardless of the source of supervision, agencies are providing additional resources of consultation, usually with members of other professions (see Table 4). Thus there appears to be ample opportunity for most workers to develop and strengthen their skills, independent of their immediate supervisors.

While some concern about the length of supervision may be appropriate, there is still a very real need to define precisely what we mean when we talk, rather glibly at times, about social workers being "oversupervised." The question is a complicated one and logically cannot be considered with exclusive attention simply to the length of supervision. Concurrently, we need to study carefully such factors as the quality of supervision, the kind of educational preparation which workers bring to an agency, and the meaning which supervision has for many workers. It is certainly not insignificant that in a study done by the Western New York Chapter, NASW, 59 percent of their respondents felt that social workers in basic practice were oversupervised on the average; yet not one respondent considered his own supervision as being "too close," although 14 percent thought it was "insufficient." [9]

INTERDISCIPLINARY PRACTICE

QUESTION: *What part of your work month involves you directly in work (collaboration, consultation, teaching) with members of other professions?*

Rationale. We hear constantly about teamwork and the need for social workers to learn to function on a team. This question was designed to learn something of the nature and extent of interdisciplinary practice.

Findings. Eighty-four percent of our respondents reported working with other professions during some part of each month, and of this group nearly one-third (30 percent) spent the equivalent of five or more days each month in collaboration, consultation, or teaching. The professional persons most frequently worked with were:

	checked by respondents
Physicians (includes psychiatrists)	321
Nurses	225
Psychologists	217
Teachers	175

[9] Western New York Chapter, NASW, Committee on Social Work Practice, "Opinions on Supervision: A Chapter Study," *Social Work*, Vol. 3, No. 1 (January 1958), pp. 20–21.

Seventy-five percent of our respondents believed their graduate education had prepared them for interdisciplinary practice; however, 45 percent indicated they had received additional in-service training to prepare them for this aspect of their work.

Analysis. Interdisciplinary practice constituted a segment of the job responsibility of a major proportion of social workers who responded to our questionnaire. It should be noted, however, that 44 percent of our respondents reported belonging to the Medical, Psychiatric, or School Social Work Sections of NASW, suggesting that they are employed in settings where extensive interdisciplinary practice is known to exist.

The fact that almost one-half of our respondents received in-service training would seem to imply a felt need on the part of administrators or workers themselves for further education in the area of interdisciplinary practice, in addition to what is offered within graduate schools of social work.

TIME STUDY

As already mentioned, 10 percent (70) of the full members of our chapter were randomly selected to receive, in addition to the questionnaire, a Time Study Schedule on which they were asked to specify how they spent each hour of a particular workday, to designate whether direct or indirect service was given, and to indicate whether they believed any portion of the activities they had performed could have been done by other than professionally trained personnel. We decided upon a 10 percent sample because of concern that the time and effort required to answer the Time Study Schedule might reduce substantially the proportion of our returns and hence the reliability of our findings. Moreover, there was some doubt that data obtained from members working in a variety of settings and using different major methods would be comparable; and there was concern that even if comparable data were secured the potential difficulties in tabulation and analysis might be so time-consuming as to delay our final report.

Assumptions. There is a tendency for workers in some settings to spend so much time in recording and other activities designed to support and further the basic function of the service that an imbalance is created and little time is left actually to discharge the basic function. Activities designed to support the basic purpose of a social agency or social work unit need to be scrutinized lest they absorb so much time that services become exhorbitant in cost to the community and needed services are not available because practitioners are overoccupied with supplementary activities.[10]

Rationale. Many commonly expressed concerns within and about our profession arise out of two problems: (1) the scarcity of professionally qualified persons to fill existing and newly created social work positions; and (2) the rising cost to the community of units of service. Some allege that too much time is spent in activities other than direct service to agency clientele; some feel the shortage of professional personnel would be alleviated if social workers could be freed from purely clerical tasks; and still others are of the opinion that many current social work duties are technical rather than professional in nature, and could be handled by specially trained technicians. The Time Study Schedule was intended to provide information about the relative amount of time social workers devote to indirect and direct services, and to determine whether workers might be willing to delegate some of their duties to other staff and then to estimate how much professional time could be saved thereby.

Findings. (Data were furnished by 35 respondents who completed the Time Study Schedule and the questionnaire.) Respondents spent 65 percent of their time in indirect services (a few examples of percentages of time: 12 percent in dictation

[10] *Delegate Assembly Workbook 1, op. cit.*, p. 25.

of case or group records; 10 percent in agency group meetings; 10 percent in contacts on behalf of, but not with, specific agency clients; 8 percent in individual supervision or consultation) and 35 percent in direct services to clients. Even those who specified direct service as their major job assignment nevertheless indicated that 58 percent of their time was still given to indirect services.

Nearly two-thirds (63 percent) of the respondents thought that no part of the work they performed could have been done by other than professional staff. Of those who would have been willing to relinquish some of their tasks and to have them assigned to nonprofessional or clerical personnel, the amount of estimated time thus saved was invariably small (with a range from ½ hour a week to 3½ hours saved on a particular day).

Analysis. If the randomness of our sample was not destroyed by those members who failed to respond to the Time Study Schedule, our findings would suggest that social workers belonging to the Golden Gate Chapter, regardless of major method of practice and of agency setting, spend on the average no more than 21 minutes out of each hour in direct service on a fairly typical workday. The important qualitative question of what would be an optimum ratio of time spent as between direct and indirect services was neither asked nor answered; our data only describe what the current practice situation is and not what it should be.

Most respondents were unwilling to yield any portion of their activities to other than professionally trained personnel. In view of the often expressed concern and dissatisfaction on the part of administrators and workers about the amount of professional time utilized in indirect services, it might be well to investigate the reluctance of many workers to give up some aspects of their job which do not directly involve clients. Pointed up is the need to define the component tasks of professional, nonprofessional, and clerical personnel in social work in order to maintain and assure the quality and quantity of the services which agencies render to communities.

SUMMARY AND CONCLUSIONS

We have described the way in which the Social Work Practice Commission of the Golden Gate Chapter undertook to construct and circulate a mail questionnaire as a means of studying some specific and some broader aspects of current practice. With the completion of our study, several purposes were served:

1. Judging from the volume of our returns, we stimulated members to look at their everyday practice and furnish us with information about it.

2. We gained a descriptive picture of 62 percent of the full members of our chapter with respect to their employment, education, experience, and salaries.

3. We assembled and provided our chapter with information pertinent to questions of NASW policy, which may in time be reconsidered by the Delegate Assembly. Decision-making may thus become more rational.

4. We highlighted for our chapter and its various commissions, Sections, and committees a few areas of social work practice which are in need of more intensive study.

5. Our salary data (Table 1), made available to our Personnel Standards and Practices Commission, have already become a part of a study of social work salaries in the San Francisco Bay Area.

6. Upon request, preliminary findings related to the private practitioner were discussed and shared with a faculty member of the School of Social Welfare, University of California, Berkeley, who is supervising a graduate student research project on the subject of private practice.

Over an eighteen-month period our practice commission devoted a total of seventeen meetings, sometimes twice a month, to the questionnaire, plus many

additional hours of homework given to compiling and analyzing data. As nearly as we could estimate our time, the entire project represented the contribution of approximately 500 man-hours to the study of social work practice. The total cost of printing and mailing the questionnaire was close to $150. When one considers the limited research skills of our commission and, on the other hand, the generally rewarding results of our efforts, the investment of time, money, and energy seems undeniably modest.

Certainly the areas of social work practice which would benefit from more orderly and systematic methods of inquiry are unlimited; and if we are to advance professionally a great many social workers will need to take responsibility, individually and collectively, for subjecting their practice to closer scrutiny. Hopefully the day may soon come when we will no longer be satisfied to rely upon empirical evidence alone, nor upon the presumed validity of our many undocumented hunches about practice—however reasonable they may seem. Concerted and earnest efforts must be made to put our diverse and ill-assorted notions about what we do as social workers to some more rational test. It seems indisputable to us that a great number of studies, both large and small, will be needed before we can clearly define the many elements of our practice and circumscribe the area of our competence. This is especially essential now that the profession is working on the complicated and controversial question of regulating social work practice, whether by voluntary or legal means.

We think we have made a useful and promising start in the direction of expanding our knowledge of social work practice, and hope other commissions and committees throughout the country will be encouraged by our experience. Were we to repeat our brief, but adventuresome, excursion into the field of social work research, we believe we would be a good deal wiser about some of the practical difficulties encountered in the construction of questionnaires. For example, we would try even harder to be precise in the formulation of questions and specific in our definition of terms; for we found that, in spite of our care, some misunderstandings did occur which were not evident in our pretest. Also, since the answers one obtains are always a function of the way in which questions are asked, we might in the future want to experiment, for comparative purposes, with several different versions of our questions. In retrospect, we know that in any new study we can go as far as our ingenuity, our interest, and our technical and financial resources will take us.

The findings of our study now need to be tested against practice and experience elsewhere to determine whether we can, at this point, make valid generalizations about any aspects of our practice.

BY MURIEL W. PUMPHREY

Transmitting Values and Ethics Through Social Work Practice

IN THE BAFFLING problem of how to communicate social work values and ethics, it is the practitioner at the direct service level who can now do most to move the profession forward. Our theorists have developed many excellent abstract formulations of professional goals and ideals, but so far most listings have been so general in nature and so similar to phrases heard in street-corner orations and radio bombast that it is hard for a newcomer to see how such declarations can be directly applicable and useful in determining what the professional person does. Students are fundamentally interested in perfecting their own performance and invest their greatest effort in learning what they see as immediately related to the improvement of their own skills.

It is not at all difficult to induce a would-be social worker to affirm convictions verbally and to explain and justify them fluently. Coming out of a democratic society, most of those selected to be our future practitioners have a long-developed allegiance to principles such as the worth of the human person, the importance of self-determination, and the right to social participation. Students from all over the country have said that their greatest difficulty is in seeing how these and many other expressed values operate in the solution of specific problems in practice—how they help make what the social worker does different from what a well-meaning non-social-worker might have done. Too often it has even seemed to students that the performance they observed was out of keeping with the descriptions of ideal social work behavior they were being told to read.

A profession is a group of people with special tasks to perform, who openly avow or "profess" a hope that some specific changes can come about in society as a result of their effort. They declare themselves to be proficient in applying to the affairs of others a specialized knowledge in some department of learning in such a way that the desired goals can be attained. So far, we have lacked ways of linking the philosophic aspects of our knowledge to our everyday doing. Our philosophic base has been regarded more as a backdrop than as essential furniture on the professional stage. Social work has tended to keep its ideals expressed in highly abstract phraseology to be aired on ceremonial occasions, and to focus its activity on the immediate technical problems involved in each situation.

We need a great body of positive examples. How a firm commitment to certain goals and a constant awareness of what kinds of behavior are approved as professionally ethical governed a practice decision of an experienced worker. How they

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helped determine the way in which his knowledge and skill were mobilized. How his treatment was selected and carried out. Workers in casework, group work, and community organization have all said how self-conscious they feel when asked to share such examples. "It sounds preachy and self-conceited," one explained. Yet he found it relatively easy to produce an illustration of how a personal emotional experience had dulled his diagnostic acuity when a client was going through similar stress—something about which he might well have been self-conscious.

Supervisors have found it easier to illustrate violation of ethical standards than to furnish even a few examples of standards adequately met; yet surely there was more ethical than unethical—more value-based than value-defying—social work being performed under their guidance. One assumes that a "good" group worker does not broadcast the confidences of members of his group; that all caseworkers respect the dignity of the human person; that each community organization social worker is motivated by the belief that society must furnish the means for meeting basic human needs. Each practitioner could make a tremendous contribution to the profession by taking a hard look at his own performance and sharing a few of his experiences when such values have actually helped him to make a professional choice.

In the long run, it is only the practitioner who can demonstrate to the new professional that a social worker's values can be more than fine words to fall back upon at some future time for the introduction to a conference paper. This should be no more difficult than to bridge the gap between other kinds of theory and everyday practice. Social workers active in the period from 1915 to 1925 describe how certain they felt that psychology was directly applicable to what they wanted to accomplish. They were convinced that more of it should be studied; they liked to mouth its terminology; they enjoyed listening to theoretical papers—but they were at a loss to show concretely where it might be applied. Now, of course, any diagnostic statement that ignored such material in describing a future treatment plan would be regarded as the work of an amateur. Nor is the social worker's statement exactly what the psychiatrist or psychologist would produce; rather, it is the social worker's utilization of that body of theory. Just so, we ought to be able to make much clearer than we do how a social worker can help democracy come alive—how a social worker daily gives a modern illustration of some of the ageless obligations of love for man and compassion for suffering.

The difference between the early introduction of psychiatric understandings and our current urge to analyze the use of values is that, as a profession, we have always been at least somewhat aware of our idealistic underpinnings. Commitment and dedication have never wholly gone out of fashion, though the professional worker's manner of indicating their impelling influence may have varied. What seems new about the recently renewed interest is the effort to incorporate the hypotheses of social sciences as to the dynamic uses of values in social interaction and personality formation. If we can learn more about how values are transformed into well-considered, skilled action, we can help move this aspect of our activities from the intuitive, highly personal side of our work to knowledgeable, skilled use which can be recognized and incorporated by each new generation instead of depending wholly on personal inclination and individual experience.

Thus an immediate—and perhaps the most important—contribution the practitioner can make is to share illustrative materials. Probably at first this exchange might best come in the form of bits of behavior rather than whole case or group histories which recount the solution of all methodological problems involved. It is not the glowingly successful, exceptional case that can help most, but everyday, typical performance ac-

companied by candid descriptions of what was in the mind of the worker. We need to show the basic philosophic equipment with which a worker consistently approaches his assigned tasks.

PROBLEM OF SEMANTICS

As we accumulate such a body of examples of genuine practical use of professional ideals and ethical standards, professional theorists may be able to rework our expressed values into terminology more graphically descriptive of social work's way of applying them. This will be a first step in the solution of one of the major problems in transmitting this material, *i.e.*, semantics. At present each of us carries into his job his own social work translation of such concepts as democracy, freedom, self-realization, self-determination, social responsibility, equality. This is so true that, in order to be certain that student, classroom teacher, and field instructor are all talking about the same operational implications, lengthy descriptions are usually necessary. For instance, probably each reader has already been filling in his own connotations for *values, ethics,* and other words so far used here.

Although it is possible to formulate abstract research definitions compatible with current philosophic, sociological, and anthropological usage, operational descriptions are usually more helpful to the practitioner who is trying to identify the ways in which values and ethics are actually applied.[1] For example: values are what an individual or group would like to see happen; what their conception of an ideal world may be; what they would preserve and the changes they would make if given the power to do so. Ethical behavior is behavior selected according to a common understanding as to what has formally or informally been adjudged as "good," following some approved principles or priorities by which selection among different "good" behaviors is made.

There is great danger in misunderstanding a single catch phrase or political shibboleth. Ann Oren, in trying to clarify professional values, described phenomena often summarized under "self-determination" by saying,

> Every person has a right to freedom in which to express his own aims and pursue them in his own way, unless this be in conflict with the rights of others . . . . Human beings normally possess some strengths, resources, and capacities for the management of their own affairs . . . . The individual, unless seriously damaged, has an urge to engage his own efforts in improving his life and his environment.[2]

Such descriptions are helpful during our present stage of groping for understanding of the dynamic uses of values, but they are awkward and hardly give a picture of what professional behavior is expected. Practitioners could help achieve more concise, exact, and diagnostically useful statements of our convictions by expressing in the words they use most often what they envision as ultimate achievements for their clients and the ways in which they might be attained. It does not seem too fantastic to foresee a time when a client's and the agency's long-range goals may be incorporated in a diagnostic statement, along with summaries of the client's value conflicts. For example, the concept of a state of anomie is no more complex or less easy to identify than is the concept of sibling rivalry, and anomie may be just as deleterious to the people involved. A whole new range of generalized goals, nearer the service currently given than our vague abstractions but showing social work behavior preferences, should gradually emerge.

[1] Muriel W. Pumphrey, *The Teaching of Values and Ethics in Social Work Education,* A Project Report of the Curriculum Study, Vol. 13 (New York: Council on Social Work Education, 1959). Compare pp. 23–26 with pp. 37–39.

[2] From preliminary material for a doctoral dissertation at the University of Minnesota School of Social Work, quoted in a memorandum by West Virginia University Department of Social Work, February 1960.

Such analysis will often require group study and interchange of ideas. There is no type of research better suited to small practitioner groups. Try to envision what theoretic clarity might involve if, as the basis for staff meetings, every worker in a settlement, family agency district, or community organization department recorded what values he thought he was trying to attain in one of his assignments and why they had been selected. Values and ethics are admittedly frustrating topics for systematic research of the traditional types. At the service level there is opportunity to invent methodologies applicable to this kind of problem. This is a department of knowledge in which the practitioner, because of his opportunity to observe the human situation, may ultimately be able to bring back theoretical concepts which will expand and illumine those of the social scientist.

Analysis should reveal patterns of usual value-based behavior on the part of the professional person. We should know what sorts of choices a professional person usually makes and where he tends to hesitate and vacillate. Almost every worker will approve many values, when they are considered abstractly one by one. Genuine professional skilled use of values comes into play when a choice must be made between two approved values. We have little verified knowledge concerning which values social workers usually place in first priority. Although there could never be absolute rules for a profession that makes one of its values the respect for individual variety and difference, it would be helpful to know some of the considerations involved in the process of choosing; which way the profession tends to lean in its preferences; and some of the reasons for this.

SOLUTION OF THEORETICAL PROBLEMS

Analysis of actual treatment situations should also prove helpful in the solution of a number of the most puzzling aspects of our professional value formation. What do we consider our primary responsibilities and obligations? Which should have the most immediate claim upon our time and creativity? Nearly every philosophic word has as many defined meanings and habitual usages as there are philosophers, and must be used at the speaker's risk.

The writer is indebted to Charles Frankel of Columbia University for pointing out differences he sees between *responsibility* and *obligation*. He regards responsibilities as consisting of those things for which people are held accountable because of their assigned tasks, specific promises, or assumption of accomplishment for reward. In other words, these are tasks undertaken, or behavior adopted, because you are hired to complete them, told to act in a certain way, or because you hope for a favorable evaluation or more than a routine raise. Obligations, Dr. Frankel thinks, are urges to act because of a feeling of compulsion that you must or should do something to help make the world as you would like it to be.

Whether or not you agree with this usage for this distinction, the distinction itself is clear. A worker might accept assigned responsibility for instituting an experimental group work program in a new housing project. He might at the same time (*because he is a social worker*) feel obligated to work for expansion of group work in institutions for the aged, with which he had no personal contact. The professional person should feel obligated to read a wide range of the professional literature in order to enhance his own skill and understanding and possibly later add to the professional store of knowledge, whereas he might be delegated to take responsibility for reading and reporting on a single work. Would most social workers always give first priority to meeting responsibilities or would they somtimes fulfill obligations first? We do not know as yet.

New workers observing the behavior of seasoned practitioners have sometimes been puzzled by what seems to them self-advanc-

ing behavior, contradictory to what they have been taught are professional obligations. For instance, they are disturbed when a directive from the board of an agency urging staff to avoid taking a public position on controversial issues results in withdrawal by the agency executive from a campaign to promote better housing. The executive probably believes his primary responsibility is to the board.

Numerous authors have indicated that primary obligation should be to the clientele served. But are we always clear as to who our clients are? What if their welfare or desire for self-determination conflicts with the needs and aspirations of other individuals? The late Helen Pendleton, the first paid trainee supervised by Mary Richmond, expressed this idea with poignant clarity when she was ninety years old. She wistfully asked this writer to tell her something about the boys and girls in her active cases. "They were my real clients, you know, back in 1896," she commented, "and how I would like to meet them now." She explained that she had longed to do more for the youngsters in the families she was serving and had enriched the lives of a good many by inaugurating game periods, home gardens, circulating libraries, and other devices to lighten the limited leisure hours of children working twelve to fourteen hours in home industry. She had felt much conflict over whether to devote all her spare time to such activities or to begin to interest prominent citizens in a program to prohibit child labor and compel school attendance. "I finally made my decision when I realized the boys and girls of 1956 were my clients, too!" Because of her persistence and that of many others like her, our clients today enjoy freedom to go to school and postpone entry into the work world. We are able to help them discover opportunities for self-fulfillment wholly out of reach of Miss Pendleton's families. Who among citizens of the year 2020 are our clients, and what is our obligation to them? One may ponder that question many times.

PRACTITIONER DEMONSTRATES VALUES IN ACTION

The practitioner can help transmit the profession's values to future practitioners by sharing his experiences in professional outreach and efforts to improve the community in which clients live. Too frequently, students are wholly unaware of the outside professional activities of staff members of their field agencies. Nothing has given students this writer has interviewed a greater feeling of professional identification than to hear about some of these current efforts during coffee breaks, or to watch workers they see every day take part in professional meetings or give public speeches. The extent and strength of professional obligations to help on many fronts by many methods was most effectively taught through such informal experiences.

Conflict of obligations is not always between society and the individual, between emphasis on direct service or social action. It sometimes occurs between the needs of two individuals served, or between the individual and others close to him. The ethical problem of determining to whom the worker owes primary responsibility and what his obligations to others may be becomes highly complex. Even in agencies dealing with single clients, probably all professional social workers would agree that the profession would expect the worker to have a continuous feeling of obligation to others involved in interaction with the client. It would be easy to dismiss the problem by saying it would all depend on the situation, but that does not help the learner to grasp the sense of obligation which a social worker carries into every situation.

A good illustration of competing ethical demands comes from a medical ward in a small general hospital.

> Ostensibly, the 40-year-old patient was brought in to determine why a minor digestive disturbance seemed to recur. Within a few hours it was obvious that

she was feeble-minded, unable to take care of any of her own physical needs, barely recognizing her relatives when they came to visit. The intern learned that this condition dated from a childhood illness. The brother and sister-in-law who had cared for her for some years since her parents' death had brought her to the hospital because they had heard that was the quickest way to gain admittance to the county home. The ward resident and the hospital administrator were clear about what they considered the hospital's responsibility. The patient did not belong on an overcrowded medical ward, since she had no treatable medical condition, and they assigned to the social worker responsibility for arranging her immediate removal.

It developed that the reason the long-suffering sister-in-law now felt she could no longer cope with the woman's care was that a sick son had returned from military service and required the only extra bedroom the small tenement flat afforded. It had been necessary to put their bright, charming five-year-old daughter in the same room with the imbecile. Conditions in that bedroom were intolerable; in spite of heroic efforts, there was continuous stench; the woman cried out in weird squeals and tore up any object that came within reach. The little girl had responded by developing a severe acne. Although their income was marginal, the family had managed to finance a private physician, who had brought the child to a private ward of the same hospital. After skin tests, a diagnosis of neurotic reaction without physical basis had been made. The child had been discharged from the hospital and the parents advised to remove the aunt.

Because the imbecile sister's parents had left a broken-down tenement house to her, with restrictions forbidding its sale, the county home declared her ineligible due to property ownership. No other institution could take her for months. The judge refused to alter provisions of the will. There was almost no net income from the house, which was in an area awaiting eventual demolition. The ward resident was adamant that the woman must be removed. It was up to the family to take her back or produce another plan. The county home admittance worker had lectured the brother on his eagerness to renounce family responsibility. The brother humbly expressed to the social worker his bewilderment and resignation. From his point of view, he had tried to meet responsibility to both sister and daughter. He felt badly that now his daughter "could not come first." It was obvious he was ready to admit defeat and call an ambulance to take the sister home.

What were the social worker's responsibilities and obligations? Who was the real client? The hospital would have been perfectly satisfied that the worker had fulfilled her responsibility if the family had been encouraged to resume the patient's care. After verifying that both the county home and the judge were immovable in their decisions, with the brother's permission the worker called a prominent community leader who was especially interested in mental hygiene and had publicly expressed the belief that the community must attack the mental hygiene problem on the preventive level. The explanation was made that here seemed to be a clear-cut example of opportunity for prevention. All reports from her kindergarten and others indicated that the child had been happy and well adjusted; her parents wanted to do a good parental job. Lack of facilities and rigidity in community rules seemed to be the obstructions. How would this committee woman think a preventive service could be accomplished? She asked for forty-eight hours to do some exploration, and the hospital reluctantly agreed to wait that long before summarily discharging the patient.

The committee woman went directly to the mayor and county political officials and told the story without revealing the patient's name. She pointed out that legally the couple probably could refuse to take

further responsibility for the sister, but their religious scruples and strong family ties had so far made it seem unthinkable for them completely to abandon her. The mayor brought pressure to bear on the county home. Somehow a bed was found, and the patient transferred.

This worker's initiative had repercussions far beyond the successful conclusion for the patient's family. The committee woman and the mayor became so exercised over the human results of the laws concerning relative responsibility and property ownership that they organized an appeal to the legislature for modification of the public institutions act. They asked permission to use this case and wanted further case illustrations. The grateful brother was more than willing to have the case used anonymously. He himself contacted his local ward politician and derived much satisfaction from entering into the community process in behalf of other families. The caseworker suggested other agencies that might have had similar experiences, and a full-blown social action program emerged, to which the worker volunteered personal time. The hospital administrator was much pleased when, at a service club luncheon, the mayor congratulated him on the foresight and sensitivity of the hospital in being so interested in preventive mental hygiene; the administrator began to question how the hospital might show more consideration for the needs of the families of patients.

This case has made excellent teaching and interpretive material. Students are challenged by the strong feeling of obligation to a client who was never seen, and the sense of urgency the worker felt to go beyond the immediate treatment requirements of the agency. They see how hospital administrators, colleagues from other professions, and the community also became clients, with consequent obligations to them. Spirited discussion results over how the desire to insure respect for human dignity, client self-determination, confidentiality, responsibility for meeting both survival and self-fulfillment needs, and the dual obligation—to potential clients who needed the bed and to a child who needed opportunity to grow healthy—all helped to determine the worker's activity.

MEETING INDIVIDUAL NEED AND THE COMMON GOOD

Practitioners can do much to speed consistent and useful value formation in words that are transmissible by analyzing how the profession meets individual need and *at the same time* promotes the common good —the philosophic question which has always plagued social work. Historically it has been solved by abrupt swings from one emphasis to the other; we are today theoretically committed to both, but rarely do we consciously see both components in a single activity.

Of all the professions, the ethical problems of the architect seem to bear closest resemblance to some of those the social worker must resolve. An architect might design an artistic building that exactly fitted the functional needs and personal aspirations of the client who commissioned it, but a number of architects have explained that he would not be considered to have fulfilled his professional obligation unless he had also made certain that the edifice would not injure any future occupant, that it did not encroach on the rights of others in the neighborhood, and that it met all legalized standards. Consideration for the wider social consequences of his creativity is viewed as part of the individual architectural service.

In reading records and listening to class and field teaching, it has seemed that the answer to the long search for the unique characteristics of social work might be found in a feeling of obligation *always* to consider social needs when dealing with individuals, and the effect on individuals when dealing with groups or communities. Testing of

this or similar hypotheses would be possible if the aforementioned treatment material could be available.

SUMMARY

To summarize, probably the practitioner's greatest contribution will be a willingness to share in a professional effort to clarify how values and ethics are used in social work diagnosis and treatment. This would involve furnishing examples from experience, assisting in analyzing them, and using value concepts when stating diagnostic impressions.

The practitioner can also help in the formulation of a more distinctive social work vocabulary with which to express values by noting what words best convey his long-range goals in what he is trying to do.

The solution of theoretical problems in the content of what is to be transmitted is also dependent on actual experience. (1) To whom is our primary obligation—who are really our clients? (2) How can values for the individual and for the society be reconciled in each social work situation?

The practitioner should also remember that at all times he is an active demonstrator of how values are applied. We know from social science research that many times values are learned through observation and nonverbal communication. It is important that every worker share his own awareness that he is practicing within an ethical framework, and that he be aware that values are motivating many of his actions.

Students will consider values and ethics an important part of the material they must master if they sense that the practitioners they see every day consider them important. They will see each case and group in terms of its simultaneous implications for individual self-fulfillment and eventual social change if they hear other workers considering such problems. What is learned through cultural exposure "by osmosis" is the practitioner's obligations; the practitioner's behavior *is* social work culture.

BY RALPH L. KOLODNY

A Group Work Approach to the Isolated Child

PHYSICAL ILLNESSES or injuries have an emotional impact, whatever their genesis and time of onset. It may be said that, irrespective of a child's emotional adjustment prior to the advent of an incapacitating illness or accident, it is virtually inevitable that emotional difficulties will follow in its wake.

Social group workers must be particularly concerned with the child's problems of social adaptation, which frequently reflect these difficulties and often compound them. Aside from his own hypersensitivity regarding his physical disability, it is more than likely that the physically handicapped child will be confronted in his neighborhood with a group of normal children who at best show but limited tolerance for his inability to participate adequately in play. This may deprive the handicapped child of those intimate associations with peers through which youngsters normally dilute the intensity of their attachment to parents and work out a more realistic and effective relationship with the world outside the home. It also places a heavy burden upon the child's family, who must provide the major resources for his recreational life.

One way to meet the problems inherent in this situation is to provide services for groups of handicapped children who meet in centrally located agencies under various auspices. Here the handicapped child may be able to reach out safely to others his own age, learn to feel more at ease with his condition, and find opportunities as he matures to take action with other handicapped people on matters of common concern. Groups of this kind perform a vital function and their growth has been heartening. They cannot, however, readily be used for homebound children, nor do they directly affect the handicapped child's relationships with his normal peers, the majority group among whom he must make his life. In fact, such groups may serve unwittingly to "ghetto-ize" the handicapped child and inhibit his entry into other relationships and experiences from which he could derive stimulation and gratification, given the proper opportunities and support.

Recognition of these facts has stimulated some organizations and agencies to involve handicapped children in substantial social contacts beyond those they have with their handicapped fellows, and to bring handicapped and normal children together in various types of groups.[1] The Department of Neighborhood Clubs of the Boston Children's Service Association has been extremely active in this effort for the past twenty years. Hopefully, our experiences will offer guidelines to others interested in this particular group of children and this important segment of group work practice.

Throughout its existence the department has primarily concerned itself with the socially isolated child.[2] Because of this it has been called upon to provide service to boys

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[1] Among such agencies have been the Community Council of Greater New York, through its demonstration project on group work with the handicapped; the Girl Scouts and Boy Scouts of America, and the New York Herald Tribune Fresh Air Fund.

[2] For a general description of the department's service *see* Ralph Kolodny, "Research Planning and Group Work Practice," *Mental Hygiene*, Vol. 42, No. 1 (January 1958).

and girls with a wide variety of physical handicaps, including a number who are homebound. These children are referred by hospital social service departments, specialized agencies for the handicapped, and—occasionally—parents. In most instances the department does not place these children in groups made up of others who are similarly handicapped. Its usual procedure is, instead, to form a club around each of the referred children in his own neighborhood, the other members of the club being drawn from among his physically normal peers. This provides the handicapped child with an opportunity to participate in the kind of group experience that would ordinarily be inaccessible to him because of his physical limitations, the reluctance of his peers to reach out to him, or his own reticence.

There are many questions to be considered in any undertaking of this kind. The issues range from those of a medical, psychodynamic, or group dynamic nature to those which relate to staff development, interagency relationships, and costs.[3] Of central importance are questions pertaining to intake, group formation, and programing. The following material focuses on these three aspects of the department's work and illustrates the procedures and problems involved in each. It also suggests the type of contribution this approach can make to the over-all rehabilitation of the handicapped child.

INTAKE POLICIES AND GROUP FORMATION

The department has consciously avoided formulating a detailed and fixed set of policies regarding the kinds of children whom we will accept for service. Our feeling is that with our present knowledge it would be premature for group work agencies to establish neatly defined criteria in this regard. It is important that considerable latitude be permitted a department such as this if it is to explore the boundaries of group work with the handicapped and is not to exclude children whose situations appear on the surface to be untreatable, but who might actually be reached by this service. We do have criteria upon which the disposition of referrals is based, but these are broadly conceived rather than sharply defined.

In order to be accepted for service the child must be socially isolated or likely to become so after hospitalization. He cannot be so intellectually retarded that he will have obvious and continuous difficulty in understanding children his own age. He may be emotionally disturbed, but not to the extent that he will be unlikely to tolerate relationships with others in a group or have any interest in program activities.[4] The child need not be ambulatory, but if he is not, he must be able to engage in a substantial range of sedentary activities. If these requirements are not met and a case cannot be accepted, the department helps the referring agency to find other resources for helping the child.

The department's acceptance of a referral does not, of course, bind the child referred and his parents to accept the service. Preliminary interpretation of the service is made to them by the referring medical social worker, but it remains for the group worker, through one or more home interviews, to make the final interpretation. If during these interviews the child and his

[3] Some of these issues have been discussed in other presentations or articles. *See* Marjory Warren, "Meeting the Specialized Needs of Handicapped Children Through Group Work," *Proceedings of the Tenth Governors' Conference on Exceptional Children* (Chicago: State of Illinois, Commission for Handicapped Children, 1953); and Ralph Kolodny, "Therapeutic Group Work with Handicapped Children," *Children*, Vol. 4, No. 3 (May-June 1957).

[4] The existence of an emotional disorder in a case referred for service becomes one more factor to be assessed. Evaluation of its implications for group work can be made by the worker, who has the benefit of the suggestions of the child's therapist, if there is such, and the advice of the department's psychiatric consultant. It is not considered by itself a sufficient reason for nonacceptance of a referral.

parents decide they wish the service (in a substantial majority they do), the worker then begins the process of forming a group.[5]

Suggestions for potential group members are usually first obtained from the youngster and his mother. If they are not in a position to suggest members, the worker, with their permission, then uses neighborhood schools or agencies as resources for this purpose. As he discusses suggested members with parents or with school or agency personnel, he keeps the following requirements in mind in assessing their suitability for the group: (1) the member should be about the same age as the referred child; (2) he should be able to accept a limited and sometimes sedentary type of program; (3) he must be able to control impulses to act out physically; (4) he should not be so competitive that he will be unable to tolerate the demands for attention which the referred child may make upon the leader; (5) he should not have displayed excessive fear of the referred child's condition if he has had previous contacts with him; and (6) there should be some likelihood of his being enthusiastic about the idea of a club as something he himself might enjoy.

Following these discussions the worker makes home visits to suggested members and their parents in order to interpret and enlist their interest in the group. Unless he is patently unsuited for the group, if a suggested member indicates a desire to join, he is allowed to do so. While this policy sometimes leads to difficulties, a rigid screening system for membership would be most difficult to operate. The use of diagnostic testing in order to evaluate suitability for membership, for example, would give rise to many complications. Even were parents to permit such testing, which is unlikely, the procedure would lead to serious problems arising from the exclusion of some of the children tested. Moreover, the selection of members according to narrowly specific criteria is often made unfeasible by the limitations of the peer population in the neighborhood.

The groups the department forms are kept purposely small—usually from five to eight members. Most begin by meeting in the handicapped child's home. As soon as it is feasible, however, meeting places are rotated so that the homes of other members are used as well. If a youth-serving agency exists in the neighborhood, meetings may be held there, occasionally at first and later regularly. The choice of meeting place and the process of movement to other meeting places depend upon a combination of factors: medical restrictions on the handicapped child's movement, his emotional readiness to leave his own home for meetings, the physical suitability of the home for meetings, the availability of neighborhood resources, and the age of group members.

PROBLEMS DURING REFERRAL AND FORMATION PERIODS

The problems that develop during the referral and formation period are equal in importance to those that arise once the group is under way and must be given equally close attention. We have found it necessary to disabuse ourselves of the notion that parents, in their gratitude for an opportunity to move the handicapped child out of isolation, will welcome this service without reservation. Most parents, of course, want their children to lead less constricted lives. At the same time, it is only natural for them, because of the various pressures to which they have been subjected in the course of their children's illnesses, to display some ambivalence when presented with the offer of this service. Isolation of the child may be bad, but exposure also has its drawbacks and parents have strong feelings about it. Under these circumstances close contact between the referring agency and the department becomes particularly necessary during the referral and formation period. Both the referring caseworker and the group

[5] In 1956, for example, in 9 of the 12 cases referred the parents and the child decided that they wanted the service.

worker must be prepared to be quite active at this time. Through accepting parental anxieties and hostilities, searching with parents for contributions they can make to the group, and showing an interest in parents as individuals, they can support them to a point where they will be able with some security to share the child with a new outsider.

Parental ambivalence is not always severe or immediately obvious, but its existence is inevitable. The group worker, therefore, must be alert to its presence and, when it is extreme, willing to understand and move with the parent as he or she hesitates, vacillates, and behaves in what may appear to be an immature way. Mrs. L, mother of a 7-year-old girl with nephritis, offers a case in point. She displayed some interest in a club for her daughter when the caseworker at the hospital spoke to her about it. The department worker who telephoned her later discovered, however, that she had some reservations. The worker suggested that she could visit Mrs. L at home to discuss them, but Mrs. L thought she would rather come to the office. An appointment was made for the next week. On the morning for which it was scheduled Mrs. L called to ask for a new time. This was set. Shortly afterward the department worker called the caseworker at the hospital and was surprised to learn the following:

> Mrs. L had come to the hospital social service office that morning and it was from here that she had called to cancel the appointment. She had made no appointment with Miss N (the caseworker) but had "just dropped in." Mrs. L had expressed much concern about the club to Miss N. She was afraid Alice (her daughter) wouldn't know how to play with other children. Miss N explained that this would be the purpose of the group, to help Alice learn to play with children her own age. Mrs. L wanted to know specifically what the group would do and Miss N mentioned that the group worker would help the members to carry out their own ideas. When Mrs. L expressed some concern that Alice wouldn't have any ideas, Miss N reassured her that the group worker would also have ideas and suggestions. Miss N reported that by the time she left Mrs. L seemed interested in the group again. Miss N believed that Mrs. L is feeling guilty about having someone else come in and do what she thinks should be her job. It became apparent, she said, that actually Alice doesn't have any friends. When Mrs. L wondered where the group members would come from, Miss N was able to reassure her by pointing out that they could come from the immediate neighborhood or nearby school.

The department worker sent a letter or reminder to Mrs. L about the next appointment, but she again canceled. She did, however, respond favorably to the renewed offer of a home visit. She and her daughter were at home when the worker came and a thorough exploration of their questions took place. The group began to meet a month later. Shortly afterward Mrs. L had another interview with the caseworker, who called the department worker and advised her that Mrs. L "seemed much more relieved about the group and was very pleased."

It is necessary also to recognize what this new experience means to the handicapped child himself and to realize that, along with the promised pleasure, it poses a threat of sorts. The group worker needs to try to reduce the child's anxiety over participation in a club by seeing him several times before the group begins to meet and building a relationship through which the child can begin to perceive him as a source of support. During these contacts he can also help the child by relating this experience to other experiences with which the child is familiar and to skills and interests he has already developed.

OBJECTIVES

Once a group begins to meet, the leader's basic objective in his work with the handicapped child is to help him to function within the limits imposed by his handicap,

but also to learn through experience the range of activities and relationships available to him despite his physical condition. Care is exercised not to deny the child's incapacities or force him to compensate for a lack of ability by becoming hyperactive. The aim is to help him discover, through testing in a protected situation, alternatives to social withdrawal or overcompensation.

Within the context of this objective various goals are developed, not only on the basis of the child's physical handicap, but also in relation to his feelings toward himself and his conception of the attitudes of others toward him. For example, in cases where the handicapped child is a homebound boy, one of the department's objectives is to provide reinforcement, through a male leader and peer group, for the child's sense of his own masculine identity. His exclusive association with his mother for long periods makes this important.

Helping the child to develop and begin to follow through on realistic vocational goals is an important objective in work with the severely handicapped youngster, who may keep this matter on the level of fantasy unless the worker, through programing and marginal interviews, enables him to take concrete steps in this direction. This attention to vocational goals, expressing the worker's confidence in the child's adequacy, can also increase the child's faith in his own capabilities.

Although the worker does not focus directly on helping the child to gain insight into, and resolve, the basic feelings associated with his handicap through the group experience, he is concerned with helping him to face and handle more adequately the problems in social relationships that accompany it. He is therefore interested in reducing whatever need the child may have to deny the reality of his handicap. At the same time, especially with the homebound child, one of the worker's objectives is frankly, through activities, sometimes to divert the child from preoccupation with his condition. Excitement and change in the life of such a child are too often confined to negative experiences such as a reinjury or recurrence of symptoms. The club gives him an opportunity to anticipate a potentially pleasurable event each week and to develop relationships with others which may afford him emotional gratification between meetings. This can help to relieve some of the depression associated with his condition.

In speaking of goals it should also be made clear at this point that, although by design this paper is focused exclusively on the handicapped child himself, this is not the case in the leader's actual work with the group. On the contrary, he is concerned with and attentive to the feelings and interests of all the members. Department workers pay close attention to the developmental needs of each group member and are also prepared to help with crises in the lives of members both within and outside the club whenever these occur. Adolescent members of a department club, for example, use this type of group as they would any other, for ventilation, information, and support around heterosexual matters, educational and vocational aspirations, and the problems of growing independence from the family. They are encouraged to do so by the worker, who uses his understanding of individual and group dynamics and his program skills to provide guidance and outlets in these areas to all the members. In addition, department workers from the very outset make themselves available as social workers to the families of all members of their groups and are frequently called upon to counsel parents or help them to use appropriate social, psychological, or medical resources. The department does not regard the normal children as figures to be exploited for the benefit of the handicapped child. While the latter may have a markedly greater need for relationships than other members, our aim is to make his association with them *mutually* advantageous.

There are five major aspects of the ap-

proach used by the worker in helping the handicapped child to move toward the goals described. These are:

1. Accepting the handicapped child's maladaptive behavior, such as overdependence, denial, and overcompensation or withdrawal.

2. As trust develops, helping him to become more aware of the effects of this behavior on his relationships with others, and of alternatives to it.

3. Enabling other members to react without undue deference or serious antagonism to his demands on the worker by giving them consistent individual attention, which includes the provision of opportunities for the ventilating of feeling about this experience.

4. Beginning with program activities well within his ability and even sometimes giving him special preparation for them.

5. Later, challenging his tendency to cling to the familiar through exposing him to carefully planned activities which are not beyond him, but which do clearly call upon him to extend himself.

In implementing these steps the worker must give careful attention to the conditions governing group interaction which are created by the presence of a youngster who is in some ways severely limited in his physical movement and whose feelings are profoundly affected by this limitation. The kinds of considerations to which the worker must pay heed might best be illustrated by a discussion of some of the issues involved in the use of program activities in a group of this type.

PROGRAMING

In groups composed of physically normal children, shoving, pulling, hugging, and wrestling are often prominent features of social interaction. The handicapped child and the members of his group, however, must exercise considerable restraint in regard to the direct expression of feeling through physical activity. The handicapped child may be fearful of his own aggressive impulses—active physical contact with another youngster may be actually dangerous for him. The other members must in some cases curb their tendency to grab or push, even in a mild way, and the usual opportunities for aggressive play of a direct sort may be denied them in this setting. Under these conditions it is important that the group's program include activities through which the generalized aggression that members may feel can be expressed and sublimated. In groups in which the handicapped child has very limited ambulation and there can be only minimal physical activity, the worker can still provide experiences through which aggressive impulses may be expressed in a controlled and enjoyable manner. The effect of the activities the worker introduces in order to provide those experiences depends, in large part, upon his relationship with the members. If he is unable to accept even verbal expressions of hostility among members or toward himself, no activity he uses is likely to provide appropriate channels for aggression. If, however, the worker feels some hostility to be inevitable, is prepared to accept it, and believes that aggression can be utilized for contructive ends, he can create a climate in which sublimation can take place.

In devising activities for this purpose he may rely on a variety of media. Wide use can be made of materials that can be struck and pounded. Clay modeling and woodworking are, of course, quite useful in this connection. Balloons may be substituted for balls in games which require throwing and hitting. Other media are also available. In round-robin story-telling, for example, in which one member begins and the others continue a story, an opportunity is afforded members to ventilate hostility if they wish and to exercise their creative urge at the same time. Some sedentary games provide youngsters with a chance to "attack" without hurting or being hurt and to "fight" without destroy-

ing. The game of "battleship" is of this type. In this game through plotting ship locations on a sheet of graphed paper, youngsters can figuratively sink each other's vessels until one team's fleet is "destroyed." Anticipation and excitement are built into this kind of game, and for the handicapped child especially, but for other members as well, there is an opportunity to release aggression that is potentially beneficial to all concerned. For, under these circumstances, youngsters may be helped to understand that, although giving vent to aggressive impulses through physical movement against another person cannot be countenanced in this type of club, the expression of aggression in some forms is natural, permissible, and constructive.

Although a well-structured and stimulating program is essential to the development of this type of group, it is important not to overemphasize this aspect of club life. Since the range of physical activity of members is limited by the presence of the handicapped child, a worker may feel under some compulsion continually to encourage the use of program activities which will create a "lively" atmosphere in the group. Implicit in this is the assumption that the handicapped child and his fellow members can only be happy when they are intensely involved in specific projects that engage all their attention. Unless he is careful, the worker may reinforce the handicapped child's tendency to rely excessively on organized projects and games as a basis for relating to others. Often such a child feels uncomfortable or even threatened if he has to relate without such props; though they bring him in contact with others, they enable him at the same time to maintain his psychological distance. While in the initial stages of the group these external supports may be essential, as the group develops the worker should encourage the attempts of members to discover spontaneous ways of relating to one another. It should also be recognized that the handicapped child in particular needs opportunities to disengage himself from activities without feeling disapproval by the worker or the other members of the group. It is important that he be given latitude to *be* with others without continually having to *do* something.

One of the persistent themes that runs through the program of a group is that of "movement." The worker is interested in helping the handicapped child to mobilize whatever capacities he has to move physically and to move out to others emotionally. It is expected that the personal investment of the worker in the child's emotional growth will be great. It should also be recognized, however, that he may likewise come to have a substantial stake in the expansion of the child's physical movement. This may stem from his concern that the child improve in every respect, but it may also be related to his own inability to face the child's realistic physical limitations. Consequently, there is always the possibility that a worker will overestimate a youngster's physical capabilities and program accordingly. This may not cause irreparable damage, but it does create unnecessary difficulties and reinforces whatever inability the child has to function within the bounds of his handicap.

To be sure, a worker will want actively to help a child make maximum use of his physical abilities. When increased physical activity can be of benefit to the child, a worker does well to devote substantial efforts to seeking out and using outside resources as well as the club program itself for promoting this.

Even as he looks for opportunities to help the child in this way, however, the worker has to avoid an exaggerated emphasis on increasing his physical activity, and to be wary lest—rationalizing his approach by saying he does not want to repeat in the group the inhibiting overprotection a youngster is receiving at home—he subtly pressure him to move beyond his physical limits. Naturally the worker wishes to avoid being overprotective. Perhaps the most direct way to accomplish this, however, is to make sure that any

activity which clearly has an element of danger in it for the handicapped child is kept out of the program of the group; in this way the leader will not be forced to be unnecessarily protective.

EFFECTS OF THE SERVICE

Questions of formation and programing are interesting, of course, but what of results? Have we seen improvement in the attitudes or behavior of handicapped children in our groups? We have seen constructive changes. We are fully aware of the complexity of this matter and the need for caution in making judgments. We have had our share of difficulties and failures. Our experiences do lead us to believe, however, that a service such as that offered by the department can be of substantial psychological benefit to many physically handicapped children.

In the case of Steve, a 12-year-old double amputee, one sees this in the contrast between the youngster's frightened response to his club's first cook-out and his reaction to this same activity a year later. The first time, despite his expression of interest and intensive preparation by the worker, Steve could not bring himself to go. He did not come to the assembly point, and when the worker stopped by his house he found Steve had suffered an anxiety attack and had been left exhausted by a severe siege of vomiting. Steve and his mother were distraught at this point and expected rejection by the worker, who had to go to considerable lengths to reassure them before going off with the group.

Some months later, however, after intensive work with Steve in the group and with his mother and Steve outside it, the youngster was able to consider going on another cook-out when this was proposed at a club meeting. This time he was ready at the appointed hour, and although at first fearful that he would be in some way overwhelmed, he soon entered into the activity with great spirit, helping to set the fire, volunteering for clean-up, and even participating in a baseball game after arrangements were made so that he could play. Throughout the afternoon he kept telling the worker what a pleasant surprise everything was.

For Linda, an 11-year-old girl with *spina bifida,* the benefits of the service became apparent after many months when she was able finally to relate, first to the worker and then to her fellow members, without anxiously concealing some of the more unpleasant aspects of her physical condition. Having come to trust in her acceptance by others, she could treat such things as her use of a catheter quite openly rather than as a dark secret. This, in turn, made it possible for her to share happily in important new areas of activity with the other members. These developments were recorded by the worker, who first began to notice a change in the youngster on one occasion when she met her at school before a trip. Linda's catheter had become caught in the upper part of her brace, causing her some discomfort. When the worker offered to help, Linda reacted with embarrassment. Their ensuing conversation is described by the worker as follows:

> I asked her if she felt funny talking to me about things like the catheter. Linda said she didn't like to think about it. I said that it was certainly easy to understand that she might be sensitive about being different from most people in this respect, adding, "But you know, Linda, I can still like you and want you to like me." Linda grinned broadly and commented that she thought I was the best club leader she had ever had.

Several weeks later when some of the members suggested an "overnight" at camp the worker was struck by Linda's ready assent and her subsequent eagerness to go. All Linda asked was that she have "some privacy." When the group planned for the trip at a later meeting Linda spoke quite openly of the medical supplies and apparatus she would have to take along. On the "overnight" itself her growing assurance and comfort with the physical

aspects of her handicap became clearly apparent. At bedtime Linda permitted the worker to accompany her to the bathroom while she emptied her catheter bag, and then indicated that she wouldn't mind if the girls stayed in the room while she changed her clothing, as long as they kept looking at the fire and toasting marshmallows. The worker describes her behavior as follows:

> Linda spoke throughout in a normal tone of voice about these more personal things and the other girls could hear very easily what was being said. She apparently feels very much at home with them. They, in turn, evinced little interest in what she was doing, whatever their underlying curiosity. After everyone had changed into her pajamas, they went to bed and, after talking a bit, fell asleep. When we visited town the next day Linda declined offers of being pushed, and wheeled herself around the shops. She was showing a noticeable amount of independence by this time and I was not asked to push the chair or lift and carry as much as before.

In some instances there occurs a substantial alteration in the handicapped youngster's capacity to respond positively to the demands of approaching adulthood. This is seen in the following abstract from a summary report on Tim, who was referred to the department by a medical social worker when he was 13.

> Tim suffered from a rare congenital disease of the skeleton characterized by brittle bones, and had sustained 25 fractures during the first 13 years of his life. He was referred to the department because he was profoundly isolated from his peers. An extremely intelligent youngster, Tim had many scientific interests. He rarely followed through on these interests, however, but confined himself to fantasies about becoming a scientist. We attempted to help him give concrete expression to his vocational aspirations and learn ways of fulfilling them realistically. During the three years his group was in existence Tim and his fellow members were introduced through various program activities to a variety of scientific projects and procedures. He developed hobbies around electronics and radio. The department worked closely with Tim's home teacher in encouraging these hobbies. At the age of 16, having had no fractures for three years, Tim began to attend high school. He did extremely well there, displaying a genuine talent in technical subjects and a striking ability to make friends with his classmates. Tim is now a college sophomore and on the way to a scientific career.

There are, of course, many problems and questions connected with our approach which will continue to concern us and which demand intensive study. We need, for example, to extend and deepen our knowledge of the impact of this type of group experience on the normal as well as the handicapped children who participate in it. We need better understanding of how to handle the tensions that sometimes arise between the handicapped child and his parents as a result of the increased independence the child has acquired through the group experience. As we help the child to relate to his normal peers we also have to learn more about how to help him, at the same time, to feel comfortable with and a part of his own minority group, the physically handicapped. Finally, we not only need to increase our understanding of the meaning of the behavior of group members but must also constantly examine our own feelings as workers in this kind of situation.

The investigation of problems such as these presents all group workers with a continuous and arduous task. If, however, we are persistent in carrying it out, we can with greater assurance help handicapped children in increasing numbers to participate in and draw emotional nourishment from group experiences with their peers.

BY LORENE A. STRINGER

Consultation: Some Expectations, Principles, and Skills

TEN YEARS AGO the St. Louis County Health Department began a program now known as the School Mental Health Services. Under contract arrangements with a number of county school districts, psychiatric social workers from the Mental Health Division are assigned to specified schools where they work, on regular schedules, in ways comparable to those of district-employed school social workers. What happened to us in the early years of the program is what can be expected to happen to most school social workers—mushrooming demands that could not be met on any case-by-case basis within the existing limits of staff time. Some of us, therefore, ventured into consultant relationships with principals and superintendents, believing that we could thus increase our effectiveness, at no extra cost or effort at all, but simply by a change of focus. What we have learned, in general, follows.

No one, apparently, will object to being called a consultant. The term has prestige value, the quietly unassailable dignity of a hallmark. *Being* a consultant, however, is something else again and not often carried off with "quietly unassailable dignity." It is likely to be either a thankless or a most arduous undertaking; the former if we do it poorly, the latter if we do it well.

The discrepancy between title and task need not concern us. Titles, after all, are intended to yield gratification, to compensate in some measure for the headaches commonly occurring in the performance of the duties that go with them. But there is a major peculiarity in the consultant's situation that adds enormously to the number of headaches he suffers. Whereas most professional titles (e.g., *physician, sanitarian, social worker, nurse, health educator*) are bestowed only on people specifically trained to perform the duties associated with them, the title of *consultant* is regularly bestowed on people trained only for some other kind of work (*e.g.*, medicine, sanitation, social work, and so on).

We can have some fine consultants in spite of this, people who have been able to train themselves, on the job, to effective performance. Not everyone has talent for self-training, but we usually overlook that fact, particularly when our attention is concentrated on the larger and sorrier fact that our staffs are never big enough to meet community need for direct services, of all the kinds that fall within the realm of settings in which social work is practiced. To be so concerned about this is appropriate, but is it equally appropriate to resort to expediency to allay our concern? And is it truly expedient if, whenever we find ourselves short of service staff, we pull a few more out of direct service, dub them "consultants," increase the number of their assignments while decreasing their time for each, and then just trust to luck?

We need consultants. It is highly improbable that we shall ever have staff re-

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sources to provide all the direct service needed; it is open to argument whether we should if we could. But we need trained consultants, because the job they have to do requires a good deal more than just that they be highly skilled in their own discipline, whatever that may be. Consider, even briefly, some of the problems they encounter as they work.

ROLE EXPECTATIONS

The consultant may or may not conceive of himself as an oracle, but many people who ask for consultation harbor a hope (unrecognized until it explodes) that he will speak - as - an - oracle - and - tell - them - exactly - what - they - want - to - hear—not just one or the other of these but always the two together. A tenth or a hundredth part of the time he may be able to do this in good conscience. The rest of the time he must choose between (1) not speaking as an oracle, which will disconcert and disappoint his listeners and raise real question about his competence, and (2) speaking as an oracle but telling them what they do not want to hear, which will upset and anger them and stimulate ideas about how they can prove him wrong. (If there appears to be another obvious choice, let us note merely that to score only once in two tries is bad enough, but not to score at all is worse.)

Let us assume, however, that all parties are reasonable and view the consultant merely as an expert in the field of his own specialization. He is still expected to be able to package his expertness neatly and have it always deliverable on demand, ready for immediate use. Here is another cluster of difficulties. In the first place, the packaging is itself an art, the end result of which must be neither too little nor too big, neither too light nor too heavy, neither too full nor too nearly empty. Moreover, the deliverable-on-demand condition is taxing. Most of us tend to mislay certain pieces of knowledge that are not often called for—to forget about this technique or that resource that proved useful once but has not been needed since. Even if one can remain unembarrassed while fumbling around the dusty shelves of one's mind, it is always frustrating to have only a dim recollection that we have something suitable somewhere, if we could just remember what and where. Third, the people who are to use this packaged expertness are not themselves experts in the consultant's specialization. They will be less than expert in it, and possibly expert in some other field. What the consultant says in his language, then, they will hear in their language, and when—not getting his message—they counter with arguments and objections, the confusion is all too often further compounded: now they speak in their language, and he hears in his.

But assume that the puzzle of semantics has been solved and communication has become full and free. There remains still a triad of odd expectations that are sometimes acted out but almost never voiced, for obvious reasons: (1) that the consultant will somehow effect the necessary changes to make everything shipshape, although he has no executive authority at all, (2) that whenever the outcome is good he will have the decency to keep out of sight, so that the credit can go to those onstage, and (3) that whenever the outcome is bad he will have the equal decency to remain out front and center, to take full blame, while the others ease quietly out of sight. All this seems patently unreasonable and unfair, but it is tightly adherent to (maybe really inherent *in*) the consultant function, so that it has to be dealt with somehow.

We are not yet being forced to set up programs for training consultants to deal with problems like these. We can doubtless go on for a long time in our present makeshift way, if only because it does not seem to be costing very much. However, this is mere seeming, and the true cost is a tremendous amount of work going undone that could be done if we had more good

consultants. We are not likely to have them until we train them; and we are not going to be able to train them until we know, rather more clearly and specifically than we do now, what particular attributes and skills differentiate a good consultant from a poor one. It is to this point that we need to address ourselves first, and it may be as good a beginning as any simply to consider how a good consultant might deal with the problems just mentioned.

THE TASK

A good consultant will not conceive of himself as an oracle. If he is truly expert in his own field, he is—by virtue of that fact—well aware that he is not omniscient. In the process of becoming expert he will have experienced failures and reversals often enough to leave him more impressed with the unpredictable and the uncontrollable than with his own ability to predict and control. All the same, when his best counsel happens to accord with what the counsel-seekers want to hear, and they therefore regard his utterance as oracular, it is tempting to offer no disclaimer but just for a little while to bask in their high esteem. It is tempting—and dangerous—for it invites them to listen more reverently the next time, when his advice may not be so much to their liking and their disappointment will therefore be sharper. He will be better off to do here, gratuitously and against whatever resistance they offer, what he has to do when his counsel is unpopular: grant that he is not infallible, admit that he cannot guarantee, and remind them and himself that his recommendation is simply his chosen way of committing himself to the as yet unknown.

In stressing the as yet unknown, however, the good consultant will not overlook or slight the matter of his own commitment. Rejecting the oracular role does not mean injecting so many ifs, ands, and buts into the discussion as to throw one's listeners into confusion and dismay, and it does not mean burdening them with all the unpredictables one can think of. This would be tantamount to rejecting the consultant role as well, because to counsel means to lend one's knowledge *and its strength.* The good consultant, therefore, will have to be able to select, out of whatever knowledge he possesses, only so much as will make the issue as clear as possible to his listeners; and whatever he proposes he will propose explicitly and firmly, committing himself unreservedly to both his recommendation and its risks, but leaving his listeners perfectly free to accept or reject it as they choose. Until the consultant so commits himself, the counsel-seekers remain shackled, not only with their own misgivings, but with their consultant's doubts and uncertainties, too.

What happens, then, when one cannot formulate a recommendation that warrants such commitment? Simply, the consultant needs to know how to say "I don't know" in a way that will inspire more rather than less confidence in him. It takes no more than forthright honesty to give this statement a good, clean impact, but if the consultant stops with that, the consultation process is likely to stop there, too. There must be follow-through, for these three unembroidered, unabashed words can open doors to fuller communication and more productive collaboration. But this counts for nothing unless the consultant moves in to stimulate new interest or encourage experimentation or suggest another point of view.

In sum, if the consultant himself has no great need to be an oracle, he can learn how to avoid the pitfalls associated with this.

It is by no means so easy a matter to learn how to make his expertness fully serviceable through consultation. The tools of his trade and his own hard-won skills are almost irrelevant now, because he is not to do the job himself, whatever the job may be; he is only to help someone else do a job—someone who, lacking the consult-

ant's skills, will not be able to use the consultant's tools. The consultant expert now has to transmute himself somehow into an expert consultant, and the problem is how.

In the first place he must take the time and invest the effort necessary to become familiar with the field to which he is consulting—with its prevalent practices, its historical great and its current local authorities, its major problems whether chronic or acute, its more important schools of thought, its terminology and jargon. He may acquire such familiarity in any of several ways, but he will not acquire it effortlessly nor in an hour or two, and until he has acquired it he will not be able to comprehend adequately the job to be done.

In the second place he must be able to appraise with reasonable accuracy the person who is to do the job, so that the tool can be matched as well as possible to the user. If the consultant either underestimates or overestimates the user, the tool will be ill-chosen—inefficient in the one case, risky or dangerous in the other. For that matter, the right tool may not be ready to hand; often enough the consultant has to be able to adapt an old tool or invent a new one before he has something right for the particular person and the specific job.

Finally, and by far the trickiest task of the three, the consultant must discover how to teach the person to use the tool so as to do the job successfully. This sounds simple, and yet it is precisely here that we are most likely to be tripped up by a suddenly erupting need to display our own expertness: we toss off a few highly technical terms and an abstruse reference or so, as a passing and surely innocent self-indulgence, and recognize too late, if at all, that these have thrown the other person off stride. We may even be tempted into mystifying rather than teaching, into saying in effect, "I have a hunch that I can't quite explain, but I think *seven* is our answer," when we could say, "Here are two, and here two more, and over there are three, making seven in all." It is not only the churlish consultant who falls into this kind of error; it awaits us all until we have learned to find it more rewarding to be a good consultant than to show off our expertness.

WHAT KIND OF PERSON?

By now, as we come to that triad of odd expectations that always attend the consultant, it is obviously time to ask what kind of person it takes to make a good one. The answer seems almost to leap full-formed out of the expectations: it takes a person mature enough to fill a parental role, supporting, encouraging, guiding, protecting whenever that is needed, entrusting whenever that is safe. What other kind of person could without bitterness take the blame when things go wrong, and yield the credit when credit is forthcoming?

The trouble with this answer is that the counsel-seekers are not children. They may be teachable and tractable, but they may be opinionated and headstrong, and they are never answerable to the consultant. Not only may they fail to be grateful for having been coached to a creditable performance, but they are often the first to attack and accuse when the coaching has not led to success. To behave parentally toward some of them is like trying to pet a porcupine.

But this is the trouble with the answer—which is not to say that the answer is altogether wrong. On the contrary, it points quite clearly to the basic and indispensable element without which no consultant can be good: the capacity to devote his energies happily and productively to building strength and furthering growth in someone else.

Again this sounds simple and is not so. It necessarily implies that the consultant has already attended adequately to his own needs and that, as new needs arise in him, he is quick to become conscious of them and able to handle them so that they do not interfere with his consultative functioning.

It means, further, that he is discriminating in the investment of his energies, neither demanding that his consultees be able to make full use, right now, of as much as he can offer, nor masochistically pouring out effort for consultees too rigid or panicked to use him at all. And it means, still further, that whatever he does is ordered, as best he can order it, to the purpose of building strength and promoting growth, not of overprotecting or overindulging or doing for.

Given this capacity to enjoy work in behalf of someone else, it becomes possible for a consultant to deal with our triad of odd expectations. Since he does not have clamoring needs of his own to distract him, he can take cognizance of certain facts that we all too often ignore: that the counsel-seekers, like grown-up children, have attained their majority, won their independence, and proved their competence in their own field; that, though they are not answerable to the consultant, they are answerable to others, somewhere, and are well aware of it; and that they have far more at stake, personally, in any issue on which they ask help than the consultant has. In the light of these facts, their expectations no longer look so unreasonable and unfair, and we may even begin to suspect that they looked that way earlier chiefly because the consultant's expectations were out of line; he was either too needy himself to be willing to work in behalf of someone else, or he did not know how to work except with executive authority, or both.

SPECIAL SKILLS

The truth is that a good consultant *can* effect change without benefit of executive authority. By sensitive listening and lucid speaking, by concerning himself to understand the consultee's problems and his potentialities, by thinking with him but from a different orientation and out of a different backlog of experience, he can move with his consultee from one new vantage point to another until the consultee begins to gain new perspective, conceive new ideas, and glimpse how they may be suited to his need. The consultant's essential function is not to do, but to enable another to do, and the most brilliant ideas the consultant may have are useless until the consultee reconceives them and makes them his own. From that point on, of course, the consultee is entitled to credit when credit is forthcoming, and the good consultant not only concedes it but points it up, knowing that the real increment of strength for the consultee, the real stimulant to his further growth, lies not so much in the credit as in the knowledge that he earned it.

Two of our three "odd" expectations are thus easily met if the consultant is willing and able to work primarily in behalf of the consultee. The third expectation, however, calls for a higher refinement of this capacity —its distillation, as it were, through further learning and greater discipline. The basic fair-mindedness that operates productively to fulfill the first two expectations now operates productively only as it *changes*, rather than fulfills, the third. The consultant cannot build the consultee's strength or promote his growth by taking all blame when things go wrong; for him to be a scapegoat helps no one in the long run. He must, of course, be ready to take his share of blame if he has share in it, but he must also know how to help the consultee tolerate as much as is his due.

This had best be done—perhaps can only be done—in advance of the outcome. A clear allocation of responsibility before the fact is always wiser than attempts to divide the blame afterward. But the consultant must be alert to perceive when the consultee is following him with more docility than conviction. Unless such following is promptly checked, a fiasco is almost inevitable, because anything that the consultee (or anyone else) does reluctantly or apprehensively is likely to be ill-done. It is usually less costly to stop and try to bring

the unvoiced reservations into the open than to risk their lingering backstage to spoil the show.

One further issue that sometimes arises in this connection merits note. Though the good consultant works in behalf of the consultee, the fact remains that these two people belong to two different disciplines, each imposing its own peculiar obligations and restrictions; and situations do occur in which the two differing sets of demands are irreconcilable. To the consultee who places great confidence in his consultant, these situations are extremely threatening. For example: a juvenile court judge found himself caught between the law, which required him to sentence a young third offender to reform school, and the recommendation of his trusted psychiatric consultant, which was in unconditional opposition to such action. What the consultant had to do in this case was to support the judge in acting *against* his (the consultant's) recommendation—to clarify for him that neither of them could ethically dodge the obligations of their different professions, but that conflict between these obligations need not impair the consultative relationship at all—on the contrary, the conflict could illumine the issues that most urgently demanded their continuing collaborative effort. This point is made because we tend to assume too easily that collaboration requires that the parties to it either think and work alike or move through a succession of compromises toward thinking and working alike. Compromise doubtless has its uses, but we need to be quite sure that it is kept subordinate to the maintenance of professional integrity, without which the consultation process becomes mere politicking.

CHALLENGE AHEAD

The aim of this discussion is to support a plea for the training of consultants, specifically those consultants who are expected to substitute somehow for unavailable service staff. It is no fun to be an untrained consultant, it is frustrating and exasperating to try to get help from a poor consultant, and it is cold comfort in either case to know that in the higher echelons a great deal of effort is going into study of the consultation process. We need research, certainly; we need good theory and thoughtful over-all planning; but meanwhile we need training, too, at the grass-roots level. And while it is true that we do not yet know how to train for this function, it is equally true that it would break no precedent in the field of social work if we were to learn by doing. We shall never learn enough without doing, and now is not too soon to begin.

BY SCOTT BRIAR

Use of Theory in Studying Effects of Client Social Class on Students' Judgments

THE RELATIONSHIP between empirical research and theory is reciprocal. One criterion for the evaluation of theory is its capacity to generate empirical research. Conversely, a primary objective of empirical research is to test and extend theory. To be productive, therefore, the relationship between theory and research should be close and continuous.

The central purpose of this paper is to describe this relationship in a specific study, an investigation of social workers' judgments. Since in describing the study major emphasis will be given to the application of theory to a specific empirical problem, space will permit only an outline of the research methods used and no more than a brief sketch of some of the study findings. In connection with the findings it should be noted that, although this research is concerned with social work judgments, the data were obtained from social work students. Thus, in this and some other respects, the study is not definitive, but does suggest implications for further research and for social work practice.

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THE PROBLEM

The social work process can be viewed as a succession of judgments made by the social worker. First, the worker forms diagnostic judgments about the practice situation that confronts him. Next, he plans a course of action, and this step involves another set of judgments. The social caseworker, for example, repeats this sequence many times in the course of a single interview. That is, in a matter of seconds, the client makes a statement, the worker attributes meaning to the client's remarks, and then selects his response from a number of possible alternatives. Some clinical judgments are made slowly, consciously, and deliberately; many occur automatically without awareness. Further, some judgments may be relatively unimportant in their effect on the client; others, such as whether a child should be removed from his own home, will have long-range consequences of vital concern to the persons involved.

In view of the crucial importance of judgment in social work practice, surprisingly little is known about how these judgments are formed and about the factors that affect them. While it is true that judgment has been receiving increasing attention in social work research,[1] for the most part this

[1] For an overview of social work research on judgment and a discussion of some of the problems involved, *see Use of Judgments as Data in Social Work Research* (New York: National Association of Social Workers, 1959).

research has been concerned with the use of judgments as data for the purpose of studying other variables. One of the best known examples of this kind of judgment research is the work that has been done on the movement scale.[2] Relatively few studies, on the other hand, have focused on judgment as an object, rather than a means of research. Notable exceptions include the studies conducted by David Fanshel, Roger Miller, and Martin Wolins.[3] Further, these two types of judgment research are not unrelated. As Hunt emphasized at the 1958 conference on "The Use of Judgments as Data in Social Work Research," "if clinical judgments are to be depended upon to represent client behavior in life situations"[4] more research is needed on the judgment process and the factors that affect it.

Among the many obstacles that arise when one attempts research on judgment in social work, two problems seem especially difficult and perplexing. First is that of obtaining systematic measures for the variables involved without departing so far from the conditions of social work practice that the data obtained would be invalidated. A second problem is posed by the large number of variables that can be assumed to affect judgment, which makes it difficult to select and isolate the most important or most strategic variables for study. An added complication is the interrelation of these two problems. To control all other variables in order to isolate the effects of a few usually requires a research design approximating the laboratory experiment, a situation often far removed from the realities of social work practice. On the other hand, to approximate social work practice conditions leaves so many factors uncontrolled that the effects of a specific set of variables cannot be isolated from others. For these reasons, effective research on judgment in social work depends, in part, on the development of research methods that will yield reliable data and yet, at the same time, bear some plausible resemblance to the conditions of social work practice.

Consequently, one objective of the study on which this paper is based was to investigate the application of a particular theoretical framework and method of approach to research on the judgment process in social work practice. A second objective was to use this method of approach to test substantive hypotheses about selected variables presumed to affect the judgments social workers make about clients. The methodological objective will be discussed first, because the substantive hypotheses can be viewed in better perspective if the approach adopted in the study is clearly understood.

JUDGMENT THEORY

Although, as noted earlier, relatively little research on the judgment process per se has been done in social work, a large number of studies in this area have been conducted in other fields, principally those of personality and social psychology.[5] In psychological research, judgment has been

[2] J. McVicker Hunt and Leonard S. Kogan, *Measuring Results in Social Casework: A Manual on Judging Movement* (rev. ed.; New York: Family Service Association of America, 1952).

[3] David Fanshel, "A Study of Caseworkers' Perceptions of Their Clients," *Social Casework*, Vol. 39, No. 10 (December 1958), pp. 543–551; Roger Miller, "An Experimental Study of the Observational Process in Casework," *Social Work*, Vol. 3, No. 2 (April 1958), pp. 96–102; Martin Wolins, "Selection of Foster Parents: Early Stages in the Development of a Screen." Unpublished D.S.W. dissertation, New York School of Social Work, Columbia University, 1959.

[4] J. McVicker Hunt, "On the Judgment of Social Workers as a Source of Information in Social Work Research," in *Use of Judgments as Data in Social Work Research, op. cit.*, p. 52.

[5] For summaries of some of this research, *see* Jerome S. Bruner and Renato Tagiuri, "The Perception of People," *Handbook of Social Psychology*, Gardner Lindzey, ed. (Cambridge, Mass.: Addison-Wesley Publishing Co., 1954), Vol. 2, pp. 634–654; Theodore R. Sarbin, Ronald Taft, and Daniel E. Bailey, *Clinical Inference and Cognitive Theory* (New York: Holt, Rinehart, and Winston, 1960); Renato Tagiuri and Luigi Petrullo, eds., *Person Perception and Interpersonal Behavior* (Stanford, Calif.: Stanford Universtiy Press, 1958).

referred to by such terms as interpersonal perception, person perception, impression formation, and predictive behavior.

A number of investigators in these fields have made use of the concept of predictive behavior to study the perceptual and inferential processes in interpersonal judgment. Predictive behavior "represents an individual's attempts to perceive, understand and anticipate his own and other people's actions in the social environment." [6] This definition of predictive behavior serves to point out that a clinical judgment involves the following sequence of events: first, the perception of behavioral attributes in others; second, the meaningful organization of these attributes within the judge's personal cognitive system or frame of reference; and third, the use of these organized perceptions to anticipate or predict the behavior of others. Seen in this context, clinical judgment behavior is merely a special instance of the more general problem of how persons perceive each other and how these perceptions affect behavior.

The basic design in studies of predictive behavior can be described as follows: Each judge is asked to predict the responses which he thinks one or more other persons, designated by the investigator, would give to a series of items. Using this design, patterned differences in *predictive judgments* can be studied as a function of other variables selected by the investigator. With some elaboration, the design can yield measures for other variables. A number of investigators have been interested in studying *predictive accuracy*. In these studies, the prediction instruments are administered to the person whose behavior is being predicted, and his actual responses are used as the criterion for measuring the accuracy of the judge's predictions. When the judge also is asked to give his own response to the prediction instruments, measures can be obtained for the degree of *similarity* between the judge and the person whose behavior he is predicting. *Assumed similarity* is the degree of similarity the judge assumes to exist between himself and the person whose behavior he is predicting. *Actual similarity* is the extent to which the judge and the person being judged are in fact similar on the instruments used. It is only necessary to call attention to the possible relationships between these variables and such concepts as understanding, empathy, social distance, and countertransference to indicate the potential relevance this approach may have for studying important questions in social work practice.

[6] James Bieri, Edward Blacharsky, and J. William Reid, "Predictive Behavior and Personal Adjustment," *Journal of Consulting Psychology*, Vol. 19, No. 5 (October 1955), p. 351.

HYPOTHESES

With this framework in mind some of the substantive hypotheses tested in this study and the theory from which they were derived can now be discussed. In this paper only hypotheses that have to do with social class theory will be presented.

On the basis of his studies of impression-formation, Asch concluded that "the views we establish of persons are, to a high degree, a function of their group-membership and group position." [7] This has a correlate in Gough's statement that "the position occupied by an individual in the social hierarchy is one of the most important variables determining his behavior." [8] These assumptions gain growing support from the increasing body of knowledge about behavioral differences between different class and cultural groups.[9] An ob-

[7] Solomon E. Asch, *Social Psychology* (New York: Prentice-Hall, 1952), p. 219.

[8] Harrison G. Gough, "A New Dimension in Status: The Development of a Personality," *American Sociological Review*, Vol. 13, No. 4 (August 1948), p. 401.

[9] The literature on this subject is extensive. Two examples of works that attempt to survey major segments of this field are Reinhard Bendix and Seymour M. Lipset, eds., *Class, Status and Power*

vious implication of this body of knowledge for research on judgment is that, if interpersonal perception is to be accurate, the judge would need to make use of social class, status, and cultural information, because some group membership differences in behavior do seem to exist.

In recent years particularly, the social work literature has stressed the importance of group membership information for the practitioner.[10] However, questions have been raised about the extent to which social workers make use of, or even obtain, this kind of information about their clients.[11] It seems important, therefore, to know more about the effects of the client's group membership characteristics on the judgments the social worker makes about him. One important kind of group membership—social class status—was selected for investigation in this study.

An attempt to predict, from theory, the probable effect of client social class on social workers' judgments posed some difficult problems. Ideally, it would have been preferable if specific, directional hypotheses could have been formulated—hypotheses, for example, of the following kind: "Social workers will tend to judge lower-class clients as more overtly aggressive than middle-class clients." However, directional hypotheses of this type seemed premature for two reasons. One is the relative lack of reliable data about class-linked differences between individuals on the specific personality and attitudinal dimensions measured by the judgment instruments used in this study. A second, more basic reason, is that even less is known, in this precise sense, about differences in *judgment* in relation to social class status as a stimulus variable. The importance of this second point is illustrated by a study that attempted to replicate some of the findings reported by Hollingshead and Redlich in their research on social class and mental illness. One of the major findings of the Hollingshead and Redlich study was that the types of disorders mentally ill individuals present to psychiatrists vary significantly in relation to the social class of the patient.[12] They raised the question of whether this relationship reflected "the *kind* of disorders patients present to psychiatrists or the *way* psychiatrists diagnose the disorders of their patients."[13] By comparing data obtained from three different psychiatric hospitals, Robert Kahn found that upper-class patients tended, more often than lower-class patients, to be given the diagnosis that was preferred in the hospital culture.[14] If, for example, the staff in a specific hospital preferred to treat schizophrenics, then upper-class patients tended to be given this diagnosis more frequently than patients from lower-class groups.

It does not necessarily follow, however, that social class will have a similar effect on judgments made by social workers. It seemed, therefore, that the first step should be to determine whether social workers' judgments are affected by client social class. If they are, then the nature and direction of the differences found would, hopefully, provide leads for further research.

Consequently, one hypothesis in this

(Glencoe, Ill.: The Free Press, 1953); and Milton M. Gordon, *Social Class in American Sociology* (Durham, N. C.: Duke University Press, 1958).

[10] *See*, for example, John M. Martin, "Socio-Cultural Differences: Barriers in Casework with Delinquents," *Social Work*, Vol. 2, No. 3 (July 1957), pp. 22–31; Walter B. Miller, "Implications of Urban Lower-Class Culture for Social Work," *Social Service Review*, Vol. 33, No. 3 (September 1959), pp. 219–236; and Otto Pollak, *Integrating Sociological and Psychoanalytic Concepts* (New York: Russell Sage Foundation, 1956).

[11] *See Cultural Factors in Social Work Practice and Education* (New York: Council on Social Work Education, 1950); and Henry S. Maas *et al.*, "Socio-Cultural Factors in Psychiatric Clinic Services for Children," *Smith College Studies in Social Work*, Vol. 25, No. 2 (February 1955), pp. 1–90.

[12] August B. Hollingshead and Fredrick C. Redlich, *Social Class and Mental Illness* (New York: John Wiley & Sons, 1958), pp. 357–358.

[13] *Ibid.*, p. 223.

[14] Robert L. Kahn, Max Pollack, and Max Fink, "Sociopsychologic Aspects of Psychiatric Treatment in a Voluntary Mental Hospital," (Glen Oaks, N. Y.: Department of Experimental Psychiatry, Hillside Hospital, March 1959). (Mimeographed.)

study was that *the client's social class status will affect the judgments social work students make about him.* More specifically, when other characteristics of a client are held constant, it was predicted that students will make significantly different judgments when different social class status characteristics are ascribed to the client.

A variable closely related to client social class, with reference to predictive behavior, is the relative distance between the social class status of the client and that of the social worker. Otto Klineberg's assertion that social class distance between social workers and their clients can "create a definite barrier to mutual rapport and understanding" [15] is echoed in many quarters. Hollingshead and Redlich, in the study mentioned above, emphasize that the distance between the patient's social class status and the social class background of the psychiatrist constitutes a serious obstacle in treatment because it hampers the psychiatrist in his attempts to understand and communicate with the patient.[16] Studies of the relationship between several types of social distance variables and interpersonal perception tend to support the assumption that this distance variable has an important effect on the impressions persons form of others.[17]

In the social work literature also, social distance, including social class distance specifically, has been recognized as a possible barrier between the social worker and the client.[18] Some writers have assumed that as the class distance between social worker and client increases, the social worker will find it more difficult to communicate and empathize with the client.[19] Empathy can be defined as the degree to which the social worker is able to establish similarities between what he perceives and senses in the client and the worker's own experiences, both personal and professional.[20] These similarities or parallels between what he sees and what he knows or has experienced provide the social worker with a frame of reference for attributing meaning to the client's communications and behavior. Consequently, it seems reasonable to infer that when a high degree of empathy exists between social worker and client, the social worker will tend to perceive greater similarity between himself and the client than when less empathy is present.

On the basis of this conception of empathy and the preceding discussion of the effects of social class distance on the social worker's ability to empathize with the client, a second hypothesis in this study was that *the degree of similarity that the social work student assumes to exist between himself and the client will be inversely related to the social class distance between the worker and the client.*

METHOD

The social worker sample in this study consisted of 130 first-year students enrolled at one school of social work. Consequently, the findings cannot be generalized to the

[15] Otto Klineberg. Unpublished manuscript, 1957.

[16] Hollingshead and Redlich, *op. cit.*, p. 301.

[17] Fred E. Fiedler, "The Psychological Distance Dimension in Interpersonal Relations," *Journal of Personality*, Vol. 22, No. 1 (September 1953), pp. 142–150; Frances B. Newman, "The Adolescent in Social Groups: Studies in the Observation of Personality," *Applied Psychology Monographs*, No. 9 (Stanford, Calif.: Stanford University Press for the American Psychological Association, 1946), pp. 29–43; Margaret G. Powell, "Comparisons of Self-Ratings, Peer Ratings and Experts' Ratings of Personality Adjustment," *Educational and Psychological Measurement*, Vol. 8, No. 2 (Summer 1948), pp. 225–234; A. Scodel and Paul Mussen, "Social Perceptions of Authoritarians and Non-Authoritarians," *Journal of Abnormal and Social Psychology*, Vol. 48, No. 2 (April 1953), pp. 181–184; Ross Stagner, "Psychological Aspects of Industrial Conflict: I. Perception," *Personnel Psychology*, Vol. 1, No. 2 (Summer 1948), pp. 131–144; and Harry O. Triandis and Leigh M. Triandis, "Race, Social Class, Religion, and Nationality as Determinants of Social Distance," *Journal of Abnormal and Social Psychology*, Vol. 61, No. 1 (July 1960), pp. 110–118.

[18] Berta Fantl, "Casework Practice in Lower-Class Districts," 1959 (mimeographed); and Miller, *op. cit.*

[19] Martin, *op. cit.*

[20] Charlotte Towle, *The Learner in Education for the Professions* (Chicago: University of Chicago Press, 1954), p. 290.

population of trained social workers, nor even to the population of social work students, since it is not known to what extent the students in this study may be representative of students in other schools of social work.

The clients about whom these social work students were asked to make judgments were obtained from the outpatient psychiatric clinic of a large city hospital. An attempt was made to select clients whose problems and behavior did not deviate markedly from that which social workers in a variety of settings might be expected to encounter. In an attempt to control for age, sex, race, religion, and family status, the selection was limited to white, Catholic mothers between the ages of 25 and 35. After screening a number of clients who met these criteria, two were selected for use in this study. Tape recorded interviews were conducted with each client. In addition, the client's actual responses to the judgment instruments were obtained.

For each client, a summary was prepared containing a description of the client, the problems she presented, her current life situation, and her past history. These summaries, plus verbatim excerpts transcribed from the recorded interviews, were given to the social work students as a basis for making their judgments about the clients. To study the effect of client social class, two summaries were prepared for each client. In one, middle-class occupational and educational characteristics were ascribed to the client, her husband, and her parents. The second summary was identical with the first in every respect except that lower-class occupational and educational characteristics were used.[21] The specific occupational and educational designations ascribed were selected from Hollingshead's *Two Factor Index of Social Position*,[22] which was the social class index used consistently throughout the study.

Three instruments were used to measure the student's judgments about each client: (1) a self-concept check-list; (2) an attitude scale that included two dimensions, acceptance of authority and traditional family ideology; and (3) an inventory of clinical judgments that social workers are frequently asked to make about clients. This discussion will be confined to use of the first two instruments.

The data were collected in two stages. In the first stage, data were obtained about the students themselves, including their social class status and social class background. The students' own responses to the self-concept check-list and the attitude scales also were obtained at this time. In the second stage of data collection, four months later, the students were randomly assigned, without their knowledge at any point in the study, to one of two groups. Each student was given a summary for each of the two clients used in the study. Depending on the group to which he was assigned, the student received *either* the middle-class summary for the first client and the lower-class summary for the second, *or* vice versa. Thus, the only difference between the client material presented to the students in groups I and II was the

[21] It will be noted that the method used to ascribe a specific social class status to the clients in this study involves an assumption that social workers are attuned to perceive a client's occupation and education as indicators of his social class position. Support for this assumption comes from several sources, but only one will be mentioned here. In a pretest for this research, 24 professionally trained and experienced social workers were asked to rank order items of information according to how well each item would serve as an indicator of a client's social class position. More than 75 percent of the social workers in the pretest ranked either education or occupation first in importance as an indicator of the client's social class status. Further, all but one of the pretest subjects assigned at least a first or second rank to one of these two items. These findings suggest that social workers do perceive occupation and education as highly important indicators of the client's social class status.

[22] August B. Hollingshead, *Two Factor Index of Social Position* (New Haven: published by the author, 1957). Grateful acknowledgment is hereby given to Professor Hollingshead for his permission to use this index in this study.

social class status attributed to the clients. After reading the summaries, the student was asked to predict the responses of each client to the self-concept instrument and the attitude scale and to rate each client on the clinical judgment inventory.

RESULTS

A major finding was that the social work students did make significantly different predictions about certain self-concepts and attitudes of both clients as a function of the client's social class status. According to their predictions, for example, both clients saw themselves as more self-confident, better liked, more independent, and more assertive when they were given middle-class status than when lower-class characteristics were ascribed to them. Further, when lower-class status was ascribed, both clients were judged to have more conforming and submissive attitudes to authority and less permissive and less democratic attitudes about family life than when these clients were given middle-class characteristics.

The second hypothesis discussed in this paper predicted that the degree of similarity between the student's own responses and his predictions of the client's responses (assumed similarity) would be inversely related to the social class distance between the worker and the client. Social class distance was measured in two ways: first, by the distance between the student's social class background and the current class status ascribed to the client; and second, by the distance between the current social class status of the student and that ascribed to the client. Actually, the latter measure was determined by the client's social class, since the Hollingshead Index defined all students in this study as belonging, currently, to the middle class.

No consistent relationship was found between assumed similarity and the distance between client social class and the student's social class background. However, the findings did reveal a tendency, which was not statistically significant, for the students to assume greater similarity between themselves and the client when middle- rather than lower-class status was attributed to the client.

SOME IMPLICATIONS

The cycle—from theory to data and back to theory again—can be completed by mentioning a few of the theoretical implications drawn from the findings of this study.

1. The findings suggest that social work students are attuned to perceive clients differently as a function of the client's social class status. However, these findings raise but do not answer this important question: Do the judgment differences that were found reflect an accurate or inaccurate use of information about the client's social class? Further research is needed to determine the validity of the differences perceived by the students.

2. Other findings from this study not presented here indicate that the effect of client social class on the student's judgment will vary with the personality characteristics of the client. This suggests the need for systematic study of the effect on judgment of the interaction between personality information and social class information.

3. With respect to the methodological objectives of this study, it should be noted that the predictive behavior approach passed two important tests. First, it led to findings that have relevance for social work practice. Second, most of the social work students were able to perform the judgment tasks with relative ease, and within the limits of their experience most of them seemed to feel that these tasks were not unlike the demands of social work practice.

BY RUTH M. PAULEY

Medical Care in Public Assistance

DEVELOPING COMPREHENSIVE medical care for all people is a task of such magnitude that it frightens and the very thought of grappling with it stifles initiative. Maybe we need to recall the famous football coach who said to his team before a crucial game, "Remember, those fellows pull their pants on one leg at a time." Unknowingly, he was suggesting in the vernacular of the athlete the basic social work principle of partialization. And perhaps partialization of the task of developing comprehensive medical care is the answer to those who sing "Just a Dreamer."

As a way of breaking this medical care undertaking into pieces small enough to understand and work on effectively, it is the proposal of this paper that we seek answers through our medical care programs for needy people administered by public welfare departments. By working on the problem in a public welfare setting we can develop knowledge and experience on which to build a broader program when the time is right.

Why is public welfare suggested as a base for experimentation and learning?

1. Regardless of the source of funds or the nature of organization for administering the payment process, comprehensive medical care must rest on teamwork among what Dr. Franz Goldmann calls the "service organization," "payment organization," and "administrative organization."[1] People seem commonly to believe that, once payment for service is provided for, the rest will be easy. Nothing could be further from the truth; when the problems of financing have been solved we will have a long way to go to meet Dr. Goldmann's criteria for comprehensive medical care. Medical care administration in public welfare aptly illustrates this.

2. Providing medical care to the needy is big business—no one knows for sure just how big—and is growing bigger almost by the hour. In the year ending June 30, 1959, over $400 million were spent on medical care for public assistance recipients in the United States. This figure does not include all expenditures across the country, since—for example—some medical care costs, particularly nursing home care, may be hidden in the money payment to the client; some are paid for by the client's family; and some are met through publicly or privately supported clinics or hospitals.

3. Public welfare agencies already have much experience in administering medical care, especially in organization for payment and the policies and procedures related to it. Generally speaking, the public assistance agencies are competently administering medical care for the needy within the limitations imposed by present knowledge and skill, and considering the quality of collaboration among health and related professions. There is probably no area of public welfare administration that

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[1] Franz Goldmann, "Comprehensive Medical Care: Basic Issues," *Social Service Review*, Vol. 29, No. 3. (September 1955), pp. 267–285.

is currently receiving greater attention.[2]

4. Public welfare agencies will freely acknowledge that not enough is known and too little consideration is given to program policies and practices aimed at restoration of health, promotion of physical and mental fitness of the healthy, prevention of disease, continuity of service in health as in sickness, adequacy in quantity and quality, and person-centered medical planning with due regard for social and economic factors.[3]

5. The administration of public welfare is a legitimate concern of responsible citizens. Health and health-related institutions, agencies, and professional groups have a duty to participate and co-operate in the development of sound medical care programs under public auspices.

6. Public welfare agencies could use a great deal more friendly and understanding assistance and guidance from health and related professions and groups in trying to bring comprehensive medical care to the needy at a cost the public purse is able to support.

NEED FOR GOOD COLLABORATION

We could have hope of bringing comprehensive medical care for the needy closer to reality if all of us who should share in its development would resolve to communicate and co-operate in a renewed spirit of faith, tolerance, and mutual respect.

One way of seeing where collaboration could be improved is to look at what happens to an individual recipient. Consider Bill Smith, released from a sanitarium after successful treatment for moderately advanced tuberculosis. He applied for and received disability assistance to supplement a small benefit from his previous employer. While receiving aid, he attended the local public health tuberculosis clinic regularly. Twice in two years he was requested by the public assistance agency to go to the clinic of a local hospital for a work tolerance evaluation, even though such an evaluation was being reported regularly to the agency by the public health department. Mr. Smith was reluctant to go to the hospital, being satisfied with his supervision at the public health department. But after three years the agency required him to go to the clinic as a condition of further receipt of assistance. It was two months before the social worker could arrange an appointment for him at the clinic.

On April 12, the day of the appointment, Mr. Smith phoned the social worker in anger saying that he had gone to the hospital but had walked out after ten minutes. He said that he would not subject himself to foolish questions and would prefer not to receive aid if he had to go through that. Nothing further happened for about six weeks, when the social worker received a letter from the hospital saying that Mr. Smith had not kept his appointment on April 12. The case was closed on May 28 because of the man's lack of co-operation. A check of the agency's medical records showed that the hospital bill for a clinic visit had been paid on April 30.

Now, what can be done to prevent occurrences of this kind?

STATE ADVISORY COMMITTEE

The mechanism on which the community at large, the health professions and institutions, and the public welfare department must rely heavily is the state advisory committee on medical assistance.[4] Its membership, the nature of its functions, and

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[2] American Public Welfare Association, "Medical Care: A Series of Reports." *See* especially: "IV. Advisory Committees in Medical Assistance Programs, May 1954," "VI. Physicians' Services, September 1954," "VIII. Drugs, June 1955."

[3] Goldmann, *op. cit.*

[4] *Guides for Medical Societies in Developing Plans for Tax-supported Personal Health Services for the Needy* (Chicago: Council on Medical Service, Committee on Indigent Care, American Medical Association, 1956); *Advisory Committees in Medical Assistance Programs*, "Medical Care," Report No. IV (Chicago: American Public Welfare Association, 1954).

the effectiveness of its operations in large measure influence the extent and quality of medical care received by individual recipients. Too often medical advisory committees are not representative of the professional groups and community resources providing medical and related services in the program. Frequently they confine their deliberations to technical aspects of administration, with emphasis on establishing fee schedules or on reviewing and advising on problems of unethical practice.

A state medical assistance advisory committee should be composed of representatives from medicine, dentistry, pharmacy, nursing, hospital administration, nursing home operators, social work, public health, rehabilitation services, research, the general public, and probably other official and voluntary health agencies. The committee's functions should include, among others, assisting the welfare department to:

Help the individual recipient obtain and use a comprehensive, person-centered health service within the limits imposed by law and appropriations.

Promote continuity of care under the client's personal physician, whether the services are rendered in the home, office, hospital, or clinic.

Develop co-operative relationships between public welfare and professional health and social work groups.

Develop co-operative relationships between public welfare, medical, and medically related institutions and agencies.

Co-ordinate public welfare with public health, mental health, and vocational rehabilitation programs.

Use community resources appropriately for the promotion of health of recipients.

Develop a program of research which will provide a sound basis for efficient and effective administration of the medical care program.

HOW IT MIGHT WORK

Suppose that the welfare department in Bill Smith's state had had such an advisory committee, and that members of the committee and the staff of the welfare department were alike committed to the principle of comprehensive medical care, as well as being dedicated to communication and collaboration toward this objective. How could this change the Bill Smith story? It might have been like this:

1. Mr. Smith received continuous personal health care for all his health needs under the direction of a personal physician of his choice from the time he left the tuberculosis sanitarium.[5] This happened because the agency had a policy providing that (a) medical care paid for by the agency must be planned with the recipient by his personal physician and directed and co-ordinated by him, and (b) the personal physician was expected to concern himself with the total medical and social aspects of the patient's case. This policy was understood and explained to the client by the social worker who helped him to make the necessary arrangements with a physician.

The physician understood the services of the public welfare department, the role of the worker in helping him to use agency and community resources, and how he could work most effectively with public welfare in his patient's behalf. The agency's objectives, policies, and the purposes of these policies in terms of objectives had been made known to him through materials published and circulated by the agency and by continuous interpretation through the medium of his professional associations.

Referral to the hospital clinic was prescribed and planned for by the physician, thus supplementing and not duplicating his care or that of the health department. The doctor explained the referral to his patient and made sure of his understanding and co-operation. The hospital, in turn, reported back to the physician.

2. The public health services which Mr. Smith obtained were tied in with and sup-

[5] *Guides for Medical Societies, op. cit.; Physicians' Services,* "Medical Care," Report No. VI (Chicago: American Public Welfare Association, 1954).

plemented the other services rendered by and through his personal physician. This was because the state public welfare and public health departments had a written agreement describing division of responsibility and interagency working relations.[6] This agreement covered patterns of co-operation in public health nursing, services for children, nutrition services, standards and licensing of institutions, and services to the chronically ill, as well as tuberculosis control.

From this working agreement the physician and social worker in the sanitarium knew what services were rendered by the public welfare department, what requirements had to be met by the patient in order to receive assistance, and what responsibility the sanitarium took in helping its patient to apply for public assistance. The agreement probably provided for the sanitarium to co-operate with the public assistance social worker in helping the patient select and contact his personal physician, also to inform the physician and the agency about the patient's general medical and social history in the institution and about plans for follow-up on his condition by the local public health department. From the working agreement, further, the local health officer knew how he was expected to work with both the personal physician and the public assistance social worker, not only in providing follow-up tuberculosis evaluation, but also in helping the patient gradually to increase his activity and return to productive employment as indicated by his condition. The public assistance social worker knew what his responsibilities were, and also those of the public health services. It is probable that the public assistance social worker was expected to make sure that the necessary steps had been carried out in Mr. Smith's behalf and to help him make use of these resources.

3. At the right time, as the patient was ready, the public assistance social worker and the personal physician helped Mr. Smith to know and use community rehabilitation resources appropriate to his situation. These might have been any of a variety of health or related services such as community workshops, vocational rehabilitation,[7] or a physical rehabilitation clinic or center. This happened because agency policy, instructional materials, and staff development programs made it possible for the social worker to understand his job as a caseworker. He knew what resources were available, who would benefit by them, and how to use them. He was able to evaluate the social implications of Mr. Smith's disability and interpret them to the physician. He understood his role of collaborating with the physician to help the recipient in increasing his self-dependence. Had the social worker found the problem too difficult to handle alone, he could have sought advice from the medical and medical social work consultants on the agency's staff. Had it been decided that referral to vocational rehabilitation was indicated, the social worker would have been guided by a written agreement between the public welfare department and the department of vocational rehabilitation. This described the mutual objectives and respective responsibilities of the two agencies, the services offered by each, and how they would work together.

4. Social workers in several institutions or agencies worked together to help Mr. Smith utilize community resources effectively. This was because the public welfare department had reviewed its organizational structure, policies, and procedures to eliminate delays in referrals and to facilitate communication between its social workers and those in other agencies. Problems in communication revealed in other agencies had also come to attention, and

[6] Jonas N. Muller and Pearl Bierman, "Co-operation Between Departments of Health and Welfare," *Public Health Reports,* Vol. 71, No. 9 (September 1956), pp. 833–848.

[7] *Working Together to Rehabilitate the Needy Disabled* (Washington, D. C.: U. S. Department of Health, Education, and Welfare, Office of Vocational Rehabilitation and Bureau of Public Assistance, July 1955).

these agencies had reviewed their practice and initiated changes designed to encourage their social workers to work closely with those in public assistance. In some instances this co-operation was sustained by interagency working agreements at state or local levels of operation.

This matter of co-operation among social workers was also watched with interest and concern by NASW and its Commission on Practice. The association had the duty to be informed about, and intervene in, this and other aspects of professional practice and ethics where necessary, just as the American Medical Association has long taken responsible action through the Committee on Indigent Care of its Council on Medical Service.

COST AND QUALITY CONTROL

Another way of looking toward improved co-operation is to consider the viewpoint of the suppliers of goods and services. In one state the average cost of drugs dispensed to recipients of public assistance increased more than $7 per recipient in four years. To control rising costs the agency imposed new limits on payments for drugs, asked for copies of all prescriptions, and—assuming that the increased costs were caused by unnecessary and multiple prescriptions and too frequent refills—sent a communication to physicians stressing that unless they used discretion in the types and quantities of drugs prescribed, the agency would be forced to impose more drastic restrictions, such as the establishment of a drug formulary or a state-operated pharmacy where all public assistance prescriptions would be filled.

This particular agency operates a really fine medical care program for the needy of the state under competent medical leadership dedicated to high-quality care. One can only be sorry for the medical director, who relies on a continuously rising mountain of paper work for himself and his staff and for the vendors of service in order to assure conformity to policy. Yet his letter to the vendors clearly reveals that his philosophy of administration has neither controlled costs nor promoted high quality of medical care to his own satisfaction.

The problem of offering good medical care without spiraling costs faces every public assistance agency today. The answer to this dilemma seems to lie in the establishment of effective medical care controls—controls which fulfill the agency's responsibility for accountability to the public without interfering in the patient-practitioner relationship [8]

Most agencies paying for a wide scope of medical services for the needy have incorporated some of the elements of quality control [9] in managing this aspect of administration, and usually this has been done with the advice of professional advisory groups. Evidence of this is found in elaborate manuals precisely defining the scope and limits of medical care for which the agency will pay, the fee and rate schedules governing payment, and the procedures to be followed in submitting bills. Another evidence is the use of operating statistics to keep the agency currently informed about the kinds and costs of various services paid for.

Nonetheless, there is probably no public welfare department that could not further strengthen its medical care controls and enlarge its knowledge of the medical services it is buying. Introducing more of the elements of quality control could augment the agency's efforts to promote good quality of care, avoid excessive expenditures, operate within its financial limitations, and foster a close and continuing relationship between physician and patient. With more application of the principles and methods of quality control, an agency could put an end to much time-consuming detailed re-

[8] Pearl Bierman, "The Positive Approach to Medical Care Controls," *Public Welfare*, Vol. 17, No. 3 (July 1959), pp. 111–114.

[9] Irwin B. J. Bross, *Design for Decision* (New York: The Macmillan Company, 1953).

view of individual bills for service, and lessen the friction between the agency and ethical and qualified providers of service.

Quality control employs certain unique but simple statistical tools to aid the agency in reviewing the quality and quantity of work, knowing whether and where a problem exists, and initiating immediate corrective and preventive action when problems are indicated. Such a system embodies four essential elements: (1) defining explicitly and in measureable terms what is to be controlled and the standards of acceptable performance on controlled work, (2) testing performance against state standards of acceptability, (3) acting when standards are not met, and (4) improving and extending the control system and adapting it to current conditions.

As an agency increases its use of the methods of quality control in administering medical assistance, it will refine, expand, and modernize its use of statistics and bring clarity to defining standards for the medical care it is willing to purchase. This approach avoids defining quality and quantity standards in rigid, absolute terms, with each deviation regarded as a problem the agency must investigate and eliminate. Quality control makes allowance for deviations from standards within controlled limits without arousing concern. It gives full recognition to the inevitable variations that must occur from patient to patient and from day to day in providing patient-centered medical care.

QUALITY CONTROL IN OPERATION

Let us consider three greatly simplified illustrations of quality control:

1. Assume a standard of quality which says that the average number of a general practitioner's visits per patient receiving care should be reasonably close to the average for all such physicians in the program. The agency's research program accumulates periodic data on this kind of service, computing the average for all and for individual physicians. Some variation from the average is inevitable, and is accepted as such by administration according to standards and control limits set with the advice of physicians themselves. But the agency looks for the cause when a given physician's visits per patient fall below or extend above the control limits laid down as acceptable. In this way the agency can locate and find an explanation for possible under- or overutilization of this particular service and take appropriate action on it if necessary.

2. From time to time statistical data may be collected on surgical procedures, such as appendectomies or tonsilectomies, for each hospital and each surgeon. The agency's standard and control limits would be based on expert knowledge and experience in the field of medicine generally. When the system indicates that the frequency of these procedures may be getting out of control in a particular hospital, or for one surgeon, the basis is at hand for further study of the individual case and —if so indicated—corrective action.

3. Regular analysis is made of the numbers and cost of prescriptions per patient visit and per prescription. These data cover the total program, and if desired can be broken down according to certain formulary items or diagnostic categories, or in other significant ways. Here again the agency's standard may say that the averages for one general practitioner should be reasonably close to the average for all general practitioners, and that the average for one pharmacist should not stray too far from the average for all pharmacists. When any one average drops too low or rises out of control, further analysis and review of these particular deviations from the standard are indicated as a basis for understanding the cause and taking appropriate corrective action if necessary.

In a quality control program the kinds of facts marshaled are those which the administrator, medical director, research director, and advisory committee find useful.

These facts can have many consequences. They may result in changes of operation within the agency, or in encouraging a particular physician to expand his treatment plans in order to prevent disease or restore health rather than confining them to routine treatment of symptoms.

More use of quality control might well give new impetus and support to the agency's efforts to foster high-quality service and discourage poor quality. It should provide the administrator with reliable facts for early and sound action to identify and resolve problems before they become acute. It should encourage rather than hinder the provision of needed services by the various practitioners of the healing arts.

SUMMARY

Providing medical care to the needy is no easy task. It merits the interest and demands the participation of many people with special knowledge and skill, both within and outside the welfare department. The state advisory committee on medical assistance is a key factor in comprehensive medical care for the needy—an instrument through which the health and health-related disciplines channel their contributions to program development. This paper has presented only a few illustrations of what needs to be done in working toward high-quality medical care for the needy, and has indicated who should feel a sense of responsibility. It proposes no answers about how to do it. Such answers must come primarily from communication and collaboration between administration and suppliers of medical care and related services. By seeking solutions to some of our problems in the administration of public welfare, we may learn what we will need to know as coverage of public medical care expands.

BY PAUL G. HOFFMAN

Significance of World Conditions for the Well-Being of People in America

I COME FROM THE nonglamorous field of economics. But even in economics, we are head over heels in social problems. The fact is that the economic programs with which I am particularly concerned—national and international—have their origin in social demands; depend for their success on the social question of human motivation; and have as their ultimate aim a social goal, the improvement of human welfare.

I shall concentrate here on ways in which world economic conditions can affect the well-being of people in America. This is not for lack of awareness of other conditions in the world which are of great significance for our own well-being. Indeed, the world today is dominated by many dangerous tensions which must be channeled constructively if we are not to suffer deeply from them. One such tension to be brought under control is that being built up between light and dark-skinned people. Another is that between the non-Communist and Communist nations.

But the most dramatic area of tension, the one most heavy in consequences for our lives in the immediate and the long-term future, is that between the rich and poor nations. It is born out of the most pervasive revolution of all time—the revolt, active and sometimes explosive, of no less than three-quarters of the world's people against the miserable conditions under which they have been living. These people are determined no longer to accept poverty, illiteracy, chronic ill-health, and despair as their way of life. This determination, this mortal blow to century-old lethargies, is what has so aptly been called "the revolution of rising expectations." It is gathering such a momentum that it justifies the new description given to it by President Sukarno of Indonesia, who at the United Nations called it the "revolution of rising demands."

This mighty social revolution has caught hold firmly in no less than 100 countries and territories associated with the United Nations and which, by any standard, must be called underdeveloped because of the dreadful poverty of their people, who number no less than 1¼ billion of our fellow human beings, not counting those of mainland China. It is on the problems of these people, and the fact that their problems are very much our own problems, that I would like to concentrate attention. This is an area that involves the very future of *our* nation, the daily lives of all of us. It involves, too, the United Nations, whose efforts to stop conflicts there is good reason to admire, and whose efforts to *prevent* social and international strife must be considered as no less important.

Let us go back somewhat in time. Until the late 1940's the task of assisting the underprivileged peoples of the world was left

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almost wholly to our churches and foundations. It is true that some colonial powers did take, in certain of their territories, measures of health and social improvement indispensable to maintaining economic productivity upon which people in the metropolitan country depended. An American rubber company, for example, did the same in respect to its plantations in Africa.

President Roosevelt's "Four Freedoms" had implied an international effort against want, and the United Nations Charter created machinery for such an effort. But it was not until the late 1940's that the idea really began to take hold in the noncolonial countries as well as in countries with colonies that, besides profound moral reasons, there were also compelling political reasons and good solid business reasons for assisting the people in the poorer countries to speed their development.

A number of governmental and intergovernmental programs, some in the preinvestment field, some for capital investment, got under way in 1948 and 1949. By preinvestment is meant those activities which prepare the way for sound investment. Included in this category are the sending of experts into countries under technical assistance programs, and providing fellowships for the training of nationals of emerging countries in educational institutions in the more advanced countries; also assistance in making natural resource surveys and in establishing research and training institutes. On the investment side, the International Bank for Reconstruction and Development, which had up to then devoted its resources largely to only postwar reconstruction loans, began making development loans. The Expanded Programme of Technical Assistance of the United Nations and President Truman's Point Four Program were initiated.

In the 1950's there was a substantial increase in assistance to the low-income countries, both in preinvestment activities and in capital investment, with additional countries setting up bilateral programs and with United Nations assistance considerably enlarged. As nearly as can be estimated, between $2 and $3 billion were spent in various types of technical assistance and preinvestment work, and some $27 to $28 billion of investments flowed from the high-income countries to the low-income countries, or $30 billion in all. In spite of this large increase in outside assistance during the 1950's, the result in terms of improved living standards for the people in the low-income areas was disappointing.

Income per person in 1950 was at a subsubsistence level. As nearly as can be estimated, it improved by a net of 10 percent during the decade, an average of 1 percent per year. This rate of improvement was obviously too slow, dangerously too slow. It meant that in 1959 at least 1 billion of the 1¼ billion people in the uncommitted world were still living in abject poverty, with illiteracy still the rule and with health conditions and housing standards distressingly low.

In this crucial decade of the 1960's—if we are to avoid more troubles to the south of us, or in Asia, more Congos—the pace of progress for these people must be sharply stepped up. Economists say that it is entirely realistic to take as a goal a 25 percent improvement in their personal incomes between now and the year 1970.

This is a modest goal. It may seem *too* modest. Nevertheless, the average figures for proposed income increases, covering as they do 1¼ billion people in 100 different country situations, conceal the exciting possibility that ten, fifteen, or twenty key countries will achieve in the decade ahead a real breakthrough toward self-generating, self-propelling economic growth. By this I mean creating economies which provide the means for steady and more rapid economic progress, while also permitting significant improvements in living conditions for a great many of their people. And nothing is more needed today than examples of additional countries that have achieved this goal under free institutions.

RESOURCES ARE NOT UTILIZED

Theoretically, the achievement of this increase in per capita income should be readily attainable—because the underlying reason for underdevelopment is underutilization of natural and human resources. Each day at the United Nations brings new evidence of the need for much more knowledge of the physical resources of these low-income countries. Not enough is known about their mineral resources, the energy their rivers could provide, the wealth in the soil, a country's industrial potentialities or markets. Yet there is every evidence that these countries have ample physical resources to permit decent lives for their people. A hint of their agricultural potential lies in the fact that farm output in metric tons per person on the North American continent exceeds the average of Asia by tenfold and of Africa by twentyfold.

A specific example of a rich but little used resource is the Mekong River. It is some 2,900 miles in length, rising in Tibet and flowing through Laos, Cambodia, Viet-Nam, and Thailand. It has a tremendous wealth-producing potential. The waters of the Mekong can be harnessed to irrigate millions of acres and at the same time meet the requirements for electric energy of millions of people. But it is only recently that surveys of this great resource, which can mean so much to Southeast Asia, got under way.

As for the human resources in the less developed nations, they have been shamefully neglected. Relatively few of the people who live in these countries have ever had the opportunity to acquire an education, most cannot even read or write and only a few have ever held positions of responsibility. Yet the people of the less-developed countries *can* be trained to be good mechanics, good farmers, good engineers, good doctors, good administrators.

The size of that task is tremendous. Of the 1¼ billion people in the 100 underdeveloped countries associated with the United Nations, I would guess that about ¾ billion persons at or over school age still cannot read or write. It would be good if they could, but even that would be far from enough. Millions upon millions of these people must be given secondary education as well. There are also immense needs for vocational training. And finally, as a critical factor in economic development, there is the necessity of training vast numbers of higher- and middle-level administrative, scientific, and technical personnel.

How many of these are required over the coming decade? Fortunately, the needs of a few of the underdeveloped countries for this skilled manpower have been estimated rather carefully. Thus, Nigeria will need to train over the next ten years 20,000 top-level administrators, professional technicians, managers, and business executives. It will also need some 40,000 middle-level technicians—for building and industrial programs, for health services, teaching, and for supervisory positions in government and business. A rough projection of these requirements would suggest that these 100 underdeveloped countries would need to train in the decade ahead at least 700,000 top-level administrative and professional personnel, and over 1,400,000 middle-level technicians. This is a staggering job, one that is impossible with the resources currently available for it. But there is no time to lose, for education and technical training must go in advance of significant economic development. Happily, the people have the capacity to learn.

Theoretically the goal suggested here for the 1960's—doubling the average rate of economic growth in the low-income countries—should be readily achieved. But practically, because of its dimensions and complexity, it is difficult of attainment. Not only are there great variations in the physical resources in the 100 different countries—in their climate, soil conditions, and water supplies. There are also economic and psychological factors about which there is much to learn. For example,

in a number of the less-developed countries, performing manual labor is considered degrading. And in other countries industrialists, entrepreneurs, and businessmen are generally regarded as third-class citizens. In still other countries political turmoil is so intense that economic development is virtually impossible. And in many countries the postponing of consumption today as an investment in a better tomorrow is a novel, if not incomprehensible, idea. In fact, the variety of conditions within and among the countries is so great that each country must be considered as an individual case.

Admittedly the dimensions and difficulties incident to the achievement of the goal for the 1960's make it a formidable task. But it can be achieved, provided we take full advantage of the experience gained in the 1950's. Many mistakes were made in that experimental decade by both recipient and assisting nations, which is not surprising. But those mistakes must not be repeated. Now is the time to approach the task with realism and intensified vigor. What are some of the things that must be done?

HOW TO ATTAIN THE GOAL

As a first and essential step toward the attainment of the proposed goal we must modernize our thinking about aid programs. We must cease thinking of them as charity. They are not charity. These countries are the great new economic frontier. If the less-developed countries are to achieve the modest goal of a 25 percent increase in personal incomes in the 1960's, they will require from the industrially advanced countries between $300 and $350 billion worth of goods and services, or double what they are now receiving. And we in the advanced countries—with our growing populations—will need these new countries as economic partners.

There is a further reason why we must not think of aid as charity. If economic assistance is considered charity, the effect on the recipient nations is devastating; it saps the self-reliance of the leaders and the people in the low-income countries. Paternalism in international relations, like paternalism in industry, generates resentment and results in halfhearted effort. No low-income country can possibly make satisfactory progress toward self-sustaining growth unless it has dedicated leaders eagerly accepting responsibility for development, and unless the people are willing to make real sacrifices and put their backs into the job. External aid can only help those determined to help themselves.

The correct attitude psychologically and practically for all countries, whether their incomes are high, middle, or low, is that they must in their own self-interest accept proportionate responsibility for the achievement of that rapidly expanding world economy which is the indispensable framework for their own progress. The first responsibility of each country is to speed its own development. Its second responsibility is to assist other nations in accordance with its means. No nation is so rich it cannot profit from the development of other countries; no nation is so poor it has nothing with which to assist other countries.

Second, helping low-income countries speed their development should be accepted as an objective worthy to be pursued for its own sake. We should recapture the wisdom uttered by the late George Catlett Marshall in his Commencement Address at Harvard University in June 1947:

> Our policy is directed not against any country or doctrine but against hunger, poverty, desperation and chaos. Its purpose should be the revival of a working economy in the world so as to permit the emergence of political and social conditions in which free institutions can exist.

Third, programs of technical assistance, especially the surveying of natural resources and the training of people in the skills they must have to make effective use of their rivers, forests, fields, and mineral wealth, must be expanded substantially.

These programs prepare the way for the greatly increased investment needed by the less-developed countries. Investment, public or private, will not venture into the dark.

Fourth, greatly expanded use should be made of the services of the United Nations and its specialized agencies operating in the developmental field. The needs of the developing nations for preinvestment and investment assistance are so great that the field should, of course, be open for any country, or organization, or group to help in any way of its choice. But the advantages—political, economic, and technical—which repose in the United Nations and its related agencies should be more widely recognized.

At the United Nations representatives of countries receiving assistance repeatedly declare their general preference for help through the United Nations—for one reason because from this source it is much more acceptable politically. Further, United Nations assistance is a completely co-operative endeavor, with a voice given to each country, whatever its size or wealth, and with all countries contributing to the costs. On the other hand, the United Nations can be "tough" with the underdeveloped countries without being accused of seeking any political or commercial advantage. Further, better results can be obtained through United Nations machinery at substantial savings in money. And in the United Nations and its thirteen specialized agencies reposes the richest experience that can be found anywhere in virtually every field of developmental activity. Further, the United Nations draws on the whole world for the technicians needed for economic development.

MORE ECONOMIC AID NEEDED

These steps which I have urged to be taken by no means comprise all that needs to be done. They have been concentrated largely on what the United Nations can do to meet its heavy responsibilities in combating hunger, ignorance, disease, and social distress.

These hopes for United Nations assistance must not be shattered. The United Nations is doing all it can with what it has in the way of resources. But those resources are pitifully small for the large part it is expected to play in the development of 100 countries with 1¼ billion people. The total funds now available to the United Nations and its specialized agencies for technical assistance and preinvestment work amounts to only some $200 million, of which approximately $91 million comes from the United States. What is needed, and desperately needed, is to double the amount for this vital purpose.

What do I propose? First let us consider the United States situation. The current U. S. Mutual Security legislation provides for $1.9 billion for economic aid in fiscal years 1960–61. Ninety-one million dollars of this amount covers contributions by the United States to all the United Nations development assistance programs, including the Food and Agriculture Organization, International Civil Aviation Organization, International Labour Organisation, Special Fund, UNESCO, UNICEF, United Nations Technical Assistance Operations, the International Telecommunications Union, World Meteorological Organization, and World Health Organization. These are the organizations, as suggested earlier, which have the richest experience available in the technical assistance and preinvestment fields. I propose that of the additional $200 million needed, the United States Government contribute $100 million. I urge that it be given unconditionally. I urge this because the need is crucial and time is of the essence. I urge it because in no other way can $100 million be made so productive in terms of economic development. I urge it as the most effective means for the United States to earn the good will of the less-developed countries of Africa, Asia, the Middle East,

and South America. And I urge it because it would be good for our souls.

As for the remaining $100 million, I propose that this be raised by voluntary contributions on the part of the other 98 nations in the United Nations, with most of it coming, of course, from the high-income countries. If the United States sets the example, other nations will follow.

The time for action is here and now. We must get started with a grander strategy and greater vigor in the war against want. If we do this along the lines suggested, two things can happen. By 1970 the United Nations could celebrate a truly great and prideful twenty-fifth anniversary. But what is more, the peace and prosperity of our country and of all the other countries would have been made more secure. We would have achieved, during this critical decade of the 1960's, a momentum of such proportions that by the end of this twentieth century poverty, illiteracy, and chronic ill health would have been wiped from the face of the earth.

BY HARRY A. WASSERMAN

Social Work in the 'Best of All Possible Worlds'

DURING THE PAST twenty years, American society has undergone a conservative revolution. American economic, political, and social thought has been underpinned by a basic assumption. This conservative assumption can be stated as follows: our economic, political, and social structures work reasonably well; the task at hand is to strive for a smoother working of our institutions by creating more and more wealth—the gross national product—and to provide means of helping people in one way or another to live more comfortable lives.

This assumption has given strength to the concepts of "adjustment" and "adaptation" and has weakened the capacity for social criticism which is so necessary to effect fundamental reforms or alterations. Conservatism, which means in essence the maintenance of the *status quo,* has led to a concentration on the "psychologizing" of personal troubles. The examination of structure and value systems from an historical point of view has been almost abandoned. Classical social analysis with its emphasis on the economic, political, social, cultural, and psychological factors of human life has been overthrown, in the main, in an attempt to deal only with the psychological as if it were the sole factor in historical evolution. Erich Fromm says,

> The concentration of effort in any of these spheres, to the exclusion or neglect of others, is destructive of all change. In fact, here seems to lie one of the most important obstacles to the progress of mankind. . . . Trying to advance radically in one sector to the exclusion of others must necessarily lead to the result to which it did lead, namely, that the radical demands in one sphere are fulfilled only by a few individuals, while for the majority they become formulae and rituals, serving to cover up the fact that in other spheres nothing has changed.[1]

For example, delinquency is a personal trouble; it is also an issue. C. Wright Mills explains that "issues have to do with matters that transcend these local environments of the individual and the range of his inner life. They have to do with the organization of many such milieux into the institutions of an historical society as a whole, with the ways in which various milieux overlap and interpenetrate to form the larger structure of social and historical life." [2] The "psychologizing" of an issue such as delinquency, is, in the main, "a pathetic attempt to avoid the large issues and problems of modern society." [3]

HARRY A. WASSERMAN, M.S.W., *is senior psychiatric social worker, Jewish National Home for Asthmatic Children, Denver, Colorado. The author writes: "It is true that no alternatives to capitalism are suggested here. A Marxist might have advanced some socialist thesis, but in the author's view, socialism is not a panacea for everything from homosexuality to flat feet. What this writer is trying to communicate is the idea that the profession of social work and the great majority of social workers now accept the* status quo *with little or no question, as if this were the best of all worlds with some minor social flaws that can be patched up. This uncritical acceptance is one of the reasons why social action remains principally a militant phrase instead of a highly organized, persistent purposeful activity."*

[1] Erich Fromm, *The Sane Society* (New York: Rinehart & Company, Inc., 1955), pp. 271–272.

[2] C. Wright Mills, *The Sociological Imagination* (New York: Oxford University Press, 1959), p. 8.

[3] *Ibid.*, p. 12.

Social work as a profession has generally accepted this conservative assumption, which has thereby aligned the profession within the framework of the *status quo*. The past twenty-five years have seen a steady absorption of psychoanalytic theory into social work theory and practice. Although psychoanalysis has made a tremendous contribution to the understanding of individual and family psychology, it has, at the same time, reinforced the trend of avoiding larger public issues. This essentially conservative drift has resulted in the refinement of techniques which has become the major emphasis of professional activity. Social work research and administration have reinforced this basic trend. During the past several years social work has reinterested itself in the findings of the social sciences. This trend is indicative of the profession's need to enlarge its conceptual base. However, the traditional social sciences are, in the main, bogged down with the problems of epistemology, research methodology, and theory construction.

PALLIATION OR PREVENTION?

During this period, too, there has been a continued emphasis on the need for social action on the part of social workers and social work organizations. This activity on the local level has taken the form of putting pressure on city governments to maintain or expand general assistance funds without interpreting the root causes of need for general assistance or suggesting methods for solving such fundamental problems. On the national level, social work organizations have supported extensions of the Social Security Act without any profound explorations as to the causes for the alienation of older people from the main currents of American life. Social action, on the part of the social work profession, has been primarily of a mildly reformist nature. Fromm explains,

> There is reform and reform; reform can be radical, that is, going to the roots, or it can be superficial, trying to patch up symptoms without touching the causes. Reform which is not radical, in this sense, never accomplishes its ends and eventually ends up in the opposite direction .... The true criterion of reform is not its tempo but its realism, its true "radicalism"; it is the question whether it goes to the roots and attempts to change causes, or whether it remains on the surface and attempts to deal only with symptoms.[4]

During the 1940's and 1950's, social work saw its role as helping a segment of the population to accommodate to the tensions and anxieties of daily living. Social workers have been combating or palliating the effects of social deterioration rather than examining the causes. Cause, not effect, is connected with structure. According to social work and public health theory and practice, the prevention of ills can be brought about primarily by the eradication of causal (etiological) agents. Hence, in the field of prevention, social work has not been an effective agent. The various social problems of delinquency, alcoholism, criminality, unwed motherhood, and the multiproblem family have continuously increased during the years; though certainly social work is not the sole profession interested in, and responsible for, the solution of these problems. In many of these problems, legal and medical aspects are so entangled with the social aspects that social work cannot be expected to carry the full responsibility in seeking solutions. Regardless of the various social problems with which social work deals, however, palliation rather than prevention has been the principal activity.

As long as social work is content to operate within the framework of conservatism, and in acquiescence with it, social work cannot be a truly dynamic force in our society. Though much of the profession's effort is exerted in the field of interpersonal relationships, there can be no effective

[4] Erich Fromm, *op. cit.*, p. 273.

attack on the problem of these interpersonal relationships unless there is some alteration in the basic framework of our society. This framework consists of the combined economic, political, and social structures of the society, from which the ideologies and myths of a nation spring. For instance, the economic system known as capitalism or private enterprise has certain definite influences upon human behavior, though in itself capitalism as a structure and process is an impersonal force. With the decline of liberal and radical thinking and the arresting of social progress during the past twenty years, the people have become more and more tenacious in their faith in the American economic system. For example, no organized segment of our society, political or professional, has even questioned the effects of capitalism on human behavior. Social work, too, has simply accepted the economic, political, and social system as a given framework within which a concerted attempt is made to deal with social problems, without ever re-examining that framework. This is conservative and dangerous, because the profession will be perpetually faced with the task of finding a method for its basic humanitarian beliefs within a structure that is perhaps incapable of generating these beliefs. Without an intensive examination of structure, the search for method is bound to be abortive. The present principle of social work thinking is that method takes precedence over structure, whereas the reverse is true. A method takes its form and direction from the given structure.

TWO BASIC PROBLEMS

There are two fundamental problems with which our society must struggle in order to move ahead toward more healthy and creative goals:

1. Can man control the technical and social machinery he has created?

2. Can man create an ethos which develops the co-operative impulses instead of selfish acquisitiveness and aggression?

As to the first, social workers who try to help people with their everyday problems and who see the hurts and struggles of disorganized lives, are unquestionably a storehouse of information on how people feel manipulated by huge, impersonal forces such as television and false advertising; how alienated they feel from work without a sense of purpose. "Man is not only alienated from the work he does and the things and pleasures he consumes, but also from the social forces which determine our society and the life of everybody living in it."[5] Work as a potentially productive and creative force has simply become a part of the anonymity of social forces to which modern man has succumbed.

Concerning the second problem, social work has never believed in the condemnation of man through original sin. Human nature is not an unalterable given. "Man is a social being with a deep need to share, to help, to feel as a member of a group."[6] It is imperative for social workers, in conjunction with the liberal, progressive political forces of our society, to probe deeply into the sickness of American society and then to develop the ideas for a radical transformation within the context of democratic principles.

The postwar scramble for consumer goods, the Korean war, the cold war and its emphasis on armaments, McCarthyism and intellectual conformity, the continuation of the various un-American activities committees and the obsession with security have produced a climate and set of values in this country which impair social progress. There has been no vigorous attempt to deal with social problems. On the individual level we are absorbed with the consumption of goods—in sum, a blind, pervasive acquisitiveness; on the local community level, with the insufficiency of energy and monies to tackle social problems; on the national level, with the

[5] *Ibid.*, p. 137.
[6] *Ibid.*, p. 140.

employment of energy and monies for security—hence armaments. At the same time, there is constant soul-searching and diagnosis of our educational system, child-rearing practices, and religious and value systems. There are a plethora of writings on every social ill with which we are confronted. We do more and more research into every aspect of the social and behavioral sciences—and paradoxically, our social problems increase in scope and intensity. Yet on the level of action very little happens.

PROBING THE STATUS QUO

Very little can happen until we begin to examine the basic assumption that is the ideology of the *status quo,* namely, the assumption that we live in the best of all possible worlds, which only needs some touching up to make it perfect. That is why most of the soul-searching and diagnoses are essentially abortive.

In the mental health field, for instance, it takes little courage today to carry on educational activities for more psychiatric clinics, better state hospitals, and the need for more professional people. It is an act of courage to question seriously the values of our society and the reasons why these imperative needs go unmet. Once the mental health advocate begins to do this he treads dangerous ground, because he will necessarily have to question the myths and ideology encompassing the economic, political, and social structures. The questions the mental health advocate might ask himself are really quite simple. How can it be that *our society* spends more on chewing gum and comic books than it does on the construction of new hospitals, clinics, and the training of professional people? What is the connection between the $250,000 a year received by the Maguire sisters for some Coca Cola jingles and the social workers' low salaries? Why are most psychiatrists trained today for private practice at $25 per hour rather than for community and social psychiatry? What are the forces in a state community (such as Colorado) that delay the setting up of residential treatment centers for disturbed children, the need of which has been talked about for almost ten years by many professional and civic organizations? The response that in a democracy the wheels of progress move slowly is evasive; apparently the same is not true for defense and security purposes.

What is the significance of this analysis for social work? First, the profession must face up to its adherence to, and support of, the *status quo.* Social workers must not accept this world as the best of all worlds and try constantly to patch up social ills in areas where only thorough and radical changes of a political and legislative nature can bring about the desired effect. Social workers have

> . . . the political task of the social scientist—as of any liberal educator—continually to translate personal troubles into public issues, and public issues into the terms of their human meaning for a variety of individuals . . . . Whether or not they are aware of them, men in a mass society are gripped by personal troubles which they are not able to turn into social issues. They do not understand the interplay of these personal troubles of their milieux with problems of social structure. The knowledgeable man in a genuine public, on the other hand, is able to do just that. He understands that what he thinks and feels to be personal troubles are very often also problems shared by others, and more importantly, not capable of solution by any one individual but only by modifications of the structure of the groups in which he lives and sometimes the structure of the entire society. Men in masses have troubles, but they are not usually aware of their true meaning and source; men in publics confront issues, and they usually come to be aware of their public terms.[7]

If there is a high incidence of personal disorganization in a specific area of a city it is not enough for the worker to influence

[7] C. Wright Mills, *op. cit.,* p. 187.

an individual client to see a psychiatrist. It is the duty of the workers in the agency, along with executives and board members to present the problem to the public, interpret its scope and significance, and determine ways and means for its amelioration, or if possible, solution. This is aggressive social work, whose purpose is to grapple with causes and prevention rather than with effects and palliation.

PLANNING

Second, the profession must, along with the other social sciences, fight militantly for integration of the concept of planning into our social machinery. Planning does not mean simply the extension of present-day bureaucratic structures because of some apparent or real need. The concept of planning entails a constant inventory-taking, through research, of the community's needs and resources. Planning is more than a makeshift tactic in response to annual budget discussions. Social research and planning are based on the existence of common human needs which are not ephemeral but of an omnipresent and universal nature. Too often social work and social progress are victimized by the whims, vagaries, and frequently the conservative intentions of the annual budget. Social work must insist that progressive social change takes into account both short-term and long-term research and planning. These necessitate huge investments of time, energy, and money so that the sense of drift is overcome and replaced by direction and purpose.

Third, social workers, along with other social scientists, must seek ways to change the supreme values of our society, which have become "Every man for himself!" and "What's in it for me?" Though this may lead social work into direct opposition to our economic, political, and social structures, social work will thereby become a dynamic force in challenging the *status quo* rather than the captive of a society anaesthetized by its own myths.

POINTS AND VIEWPOINTS

Professional Participation of Social Workers

Material used in this report was gathered with the help of persons employed by the Veterans Administration. Publication of the findings should not be taken as an indication of official approval or disapproval by the Veterans Administration. The views expressed are those of the writer.

THE U.S. VETERANS ADMINISTRATION has pioneered in raising professional standards in social work. With regard to training, this objective has been attained. This report is a by-product of a study on "Communication, Censorship, and Ritualism of Evaluative Research in a Large Organization." Twenty-seven VA stations in the western region and 19 stations in other parts of the United States co-operated by distributing a questionnaire.[1] All but 5 of the 282 caseworkers, supervisors, and administrators who responded to the survey had two years of professional education. Over 11 percent—32 of the respondents—had done three or more years of postgraduate work. Training beyond the master's degree was twice as common among supervisors and administrators as among social caseworkers.

If one uses membership in professional organizations and subscriptions to social work journals as indices of professional participation, standards were more variable. Both of these indices were directly related to administrative responsibility. Supervisors and administrators belonged to an average of 1.54 organizations as against only 0.97 for direct-service social workers; and supervisors and administrators were underrepresented in the category of 89 social workers who reported *no* journal subscriptions (see Table 1) and the 62 who reported no professional association membership (see Table 2). Failure to belong to a professional organization was closely associated with disinterest in being a subscriber to professional journals. Only 5 of the 62 persons who did not report membership in an organization reported themselves as professional journal subscribers.[2] The proportion of nonmembers in the National Association of Social Workers is slightly lower than an estimate made by that organization in 1959 that its membership includes only 76 percent of those eligible to belong.[3]

Who were these professional nonparticipants, the more than one in five who reported no membership in a professional organization? Noteworthy as missing from their ranks were the 5 workers with sub-

[1] It was not possible to check what proportion of workers in each of the stations completed the questionnaire. The sex distribution of the sample is identical with that of all social workers in the VA—60 percent female and 40 percent male.

Persons with professional education were overrepresented among the 282 respondents. About 5 percent of the social workers in the VA had less than two years of training, but only 2 percent of our sample were in this category. Eleven percent of our respondents had three or more years of postgraduate work. The national percentage of persons with advanced social work education is smaller.

[2] Membership in NASW automatically includes a subscription to SOCIAL WORK. Since only 62 persons reported no professional association membership, some of the 89 social workers who reported no journal subscriptions must be receiving SOCIAL WORK. One possible explanation for this discrepancy is that they interpreted the question about journal subscriptions to refer to those not automatically included in their membership fee.

[3] This estimate is based on unpublished regional estimates made at the request of the Executive Committee of NASW in 1959.

TABLE 1. NUMBER OF PROFESSIONAL JOURNAL SUBSCRIPTIONS REPORTED BY VETERANS ADMINISTRATION SOCIAL WORKERS •

	(Percent)		
	Social Caseworkers	*Supervisors and Administrators*	*Total*
	(N–201)	(N–81)	(N–282)
None (N–89)	41	9	31
One (N–109)	37	42	39
Two (N–58)	17	29	21
Three or more (N–26)	5	20	9
Total (N–282)	100	100	100

• Most often mentioned was SOCIAL WORK; the *Social Service Review* was mentioned by 22 respondents, *Social Casework* by 80.

TABLE 2. NUMBER OF PROFESSIONAL ASSOCIATIONS TO WHICH VETERANS ADMINISTRATION SOCIAL WORKERS BELONG

	(Percent)		
	Social Caseworkers	*Supervisors and Administrators*	*Total*
	(N–201)	(N–81)	(N–282)
None (N–62)	29	5	22
One (N–150)	53	54	53
Two (N–36)	11	17	13
Three or more (N–34)	7	24	12
Total (N–282)	100	100	100

standard professional education. All 5 were over 40 years of age; they had only one year of postgraduate work, but belonged to an average of three professional associations. None of these were among the 89 who failed to name a single subscription to a social work journal. The frequency of professional inactivity was highest among social workers with a two years' master's-level professional education. But there was also a significant minority of inactives among the 32 professionals with advanced education—three or more years of postgraduate work. Six of them did not belong to any professional organization, and 9 mentioned no journal subscriptions.

The great majority of social workers conformed to the organizational and intellectual leadership expectations commonly associated with professional education, but the existence of a significant minority of nonparticipant professionals in one of the country's high-standard social service agencies is a fact worthy of exploration. Its discovery was a by-product of a study made for different purposes. No explanatory hypotheses were systematically explored in the questionnaire, but a number of plausible *ex post facto* reasons may be mentioned.

A proportion of nonparticipants can be expected in any voluntary professional activity. We do not know how this frequency among VA social workers compares with that found in other large organizations or with inactivity among doctors, psychologists, or occupational therapists. VA stations have excellent libraries. Some of our respondents may feel it unnecessary to subscribe personally to journals they can read at work. But this will not help to explain the nonmembership of more than one-fifth in any professional organization.

Prof. Leonard Reisman suggests that professionals in large organizations generally conform to one of several types of bureaucratic role models, differing in their degree of professional identification. The nonparticipating social worker in our sample may include a large portion of persons who conform to his most organization-minded role type, that of *job bureaucrat.*

> He is immersed entirely within the bureaucratic structure. Professional skills only provide the necessary entrance qualifications and determine the nature of the work to be done. He seeks recognition along departmental rather than professional lines. Satisfactions are found in the technical aspects of the work itself, and improvement of the operating efficiency of the Bureau becomes an end in itself.[4]

[4] Leonard Reisman, "The Bureaucrat's Own Role Concepts," *Social Forces,* Vol. 27, No. 3 (March 1949), pp. 305–306. Also in Robert E. Dubin, *Human Relations in Administration* (New York: Prentice-Hall, 1951), pp. 91–95.

Professor Reisman contrasts this role model with the *functional, specialist,* and *service* bureaucrats. All of them are more concerned with professional identification. They seek recognition from a professional group outside rather than only within their organization. They would be less likely to view themselves as wedded in career to the VA.

The existence of a significant minority of professional nonparticipant social workers would not have been predicted on the basis of evidence of Norman Polansky, Clyde White, and others that social workers tend to be socially marginal in the sense of "lacking the security which may be derived from self membership in a major social group."[5] The unification of seven social work professional organizations in the NASW was welcomed by many as a step in the direction of providing social workers with a strong reference group. Nonmembership in the organization and disinterest in subscribing to its publication on the part of a minority of VA social workers suggests the possibility that they are identified more strongly with some other reference group. It should be noted that those with less than a master's degree were extremely active, and those with more than two years' education (a symbol of status in social work as in all professions) included about one in five who was professionally inactive. Could it be that they feel less need to document their professional status than do undertrained workers?

Other *ex post facto* explanations are tenable. Were some of the social workers just tired of answering questions? This explanation is implausible. All 62 VA respondents who failed to mention a professional organization membership responded to subsequent questions on the schedule.[6] Somewhat more likely is the inference that nonparticipation is related to a desire to save money. National and local membership dues in the NASW are about $25 a year.

CONCLUSION

A significant minority of social workers in the VA claimed no participation in a professional organization or any subscription to a professional journal. The reasons for their passivity were not investigated. This finding was an unanticipated by-product of an inquiry conducted for different purposes. A number of plausible *ex post facto* explanations were explored, to be checked out in future research.

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[5] Norman Polansky and Others, "Social Workers in Society: Results of a Sampling Study," *Social Work Journal,* Vol. 34, No. 2 (April 1953), p. 74; and R. Clyde White, "Social Workers in Society: Some Further Evidence," *Social Work Journal,* Vol. 34, No. 4 (October 1953), p. 161.

[6] For instance, only 9 failed to respond to a subsequent open-ended question requiring deliberation: what to study or observe if given a six-month leave of absence with pay. All 62 answered a later question regarding their research experience.

BOOK REVIEWS

ACTION FOR MENTAL HEALTH. Final Report of the Joint Commission on Mental Illness and Health. New York: Basic Books, 1961. 338 pp. $6.75.

Among the multitude of reports written, a few stand out as milestones—guideposts in their fields for a decade or more. Even fewer receive instant recognition. One such exceptional report was made by the Joint Commission on Mental Health and Illness in April. Legislators, boards of trustees, lay and professional alike have already embraced its recommendations as the blueprint for "action for mental health."

It presents a "master plan" that requires the doubling of all present expenditures for mental health services in the next five years and tripling them in the next ten, to a grand total of $3 billion. In structuring this support, the commission allocates prime responsibility to the federal government through a state and local grant program, with awards on a matching basis.

In projecting a program of federal-state co-operation involving research, training, information, and treatment the commission emphasizes the use of resources on hand. In research a creative approach is espoused, because of the relative lack of depth of the inquiry into the nature of man. A larger investment in long-time research is made a major goal through federally supported mental health research centers, to be operated independently or in collaboration with educational institutions. Whatever the means, the end is a balanced portfolio of diversified basic research.

The report recognizes the inadequacies of current training for mental health workers and endorses confirmation and expansion of the federal scholarship and loan programs for higher education. It finds a major incentive for training in the plan to amend the income tax law, permitting deductions from taxable income of direct expenses for higher education.

In view of present needs, two new general classes of workers with the mentally troubled are suggested: the *counselor* and the *consultant*. The public now goes to a variety of people for help. The commission would not attempt to change that pattern but rather to reinforce it with professional help. The mental health counselor is seen as the person *now* giving help. He is the clergyman, public health nurse, teacher, "public welfare worker *(sic)*," scoutmaster, and others who can become more effective if backed up by a short training course. These courses and consultations can be furnished when necessary by mental health consultants, trained in the mental health field. These may be psychologists, social workers, nurses, or psychiatrists with particular interest in community services.

While investigation is still being pursued, the report underscores its tentative conclusion of the critical nature of immediate need for help for the acutely disturbed. Though such help should be furnished preferably by psychiatrists, the urgent need for prompt care suggests the use of public health nurses and social workers under active psychiatric supervision.

The report will have most immediate effect through its outline for state mental health programs. In advocating abandonment of the present system of state mental hospitals, the commission envisions care by community clinics, psychiatric units in general hospitals, "open communities," and chronic disease centers. The variety of current settings for the community clinic for outpatient treatment is accepted. Clinics may be parts of general hospitals in a state system, or exist as independent agencies. More important than the setting is the

objective of one clinic for every fifty thousand persons in the population.

The report sees no general hospital as complete without its psychiatric unit. The community hospital of 100 beds or more is expected to provide short-term resident care, and the current structure of state hospitals is analyzed as falling into two groups, of which the smaller ones of 1,000 beds or less should be converted into open communities for intensive treatment. (A similar report by the Surgeon General's committee has held that a 600-bed unit is more workable as a setting for concentrated therapy.[1]) A theme running through the report in emphasizing the smaller unit is the recognition of the patient's need to be near his own family and community.

A major contribution of the publication is the concept of a chronic disease center offering care for the mentally ill and the ailing aged. This function is allocated to all existing state hospitals with over 1,000 beds. To prevent them from deteriorating into terminal infirmaries, all current techniques of socialization, relearning, group living, and gradual rehabilitation should be used.

To tide the patient over his return home and maintain him in the community as long as possible, a complete program of after care is advocated. Included is the use of day and night hospitals, after-care clinics, nursing services, nursing homes, rehabilitation centers, and ex-patient groups.

Several aspects and omissions of the commission's report have a special interest for the social worker. Great stress is laid on the patient's needs; in the struggle for status among the professions, patient service should be the controlling consideration—help should be accepted where available. However, in focusing on the institutional basis of care, the vast complex of services performed by public and private social agencies is underemphasized, if not overlooked. The very segmentation the commission seeks to avoid will result through its limited approach. Most communities have social agency facilities for present use—unrelated, to be sure, to the state mental hospital systems. In a family integrated approach to the mentally ill, no sound program can separate existing community welfare agencies from state institutional care services. Social workers are aware of the lack of relationship between the hospital and the community worker. To be consistent with its "make-do" approach, the commission should have emphasized welfare agency resources and the need to relate them more closely to mental hospitals through administrative structure and service practice.

In discussing the dearth of mental health personnel, the social worker is singled out as being presently in short supply. At this time only 18 percent of those in social work positions have had any training in the field. And rather than progressing, we are slipping back: in 1950, 23 percent of the people in social work positions had some training. Moreover, there seems to be no immediate remedy for the shortage in the near or distant future. This inability of the social worker to fulfill his community responsibilities, if only for lack of numbers, is the responsibility primarily of the profession. In a day when federal aid to allied professions is the rule, social workers stand out by being left out. The training assistance they do receive is always under somebody else's banner—vocational rehabilitation, juvenile delinquency, or the like. The amounts received do not compare favorably with sister professions. Legislators and administrations are ignorant of what social workers do and who they are—and there are very few around to enlighten them. Teachers and other professionals have a network of lobbyists, by contrast to a lone social worker on the federal lobbying scene. Until provincially oriented social agencies see that times have changed in the last ten years, federal support for social work train-

[1] Surgeon General's Ad Hoc Committee on Planning of Mental Health Facilities, "Planning of Facilities for Mental Health Services" (Washington, D. C.: U. S. Government Printing Office).

ing as such from federal funds will be lean indeed.

STANLEY J. BRODY
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FACTS, FALLACIES AND FUTURE: A STUDY OF THE AID TO DEPENDENT CHILDREN PROGRAM OF COOK COUNTY, ILLINOIS. Conducted by Greenleigh Associates, Inc. New York: Greenleigh Associates, Inc., 1961. 99 pp. plus ADDENDA, 149 pp. $2.00 per volume.

As its title suggests, this report is crammed with arresting facts about the ADC problem and ADC program administration in Cook County, Illinois; but its pertinence is in no sense confined to Chicago and Cook County. With only certain modifications in the statistics, the findings would apply to any of the large northern and western metropolitan areas which are the termini of the heavy emigration from southern states—primarily of Negroes—that has occurred since World War II and is continuing in an unbroken stream. Likewise most of the findings on the weaknesses in administration of the ADC program in Cook County, and the recommendations proposed to remedy these conditions, would apply to similar large metropolitan public assistance agencies.

It must be remembered that this is not a sociological treatise but a study oriented to suggesting administrative reforms. Yet for those who read it carefully it makes with sledgehammer force a fundamental point regarding the nature of our northern and western metropolitan communities: the rising incidence of dependence upon ADC assistance is but a symptom of social forces that are little understood or appreciated; communities are totally unequipped, psychologically or in adequate agencies, to cope with them.

Social workers who have been deeply involved in the ADC program in any capacity will find much comfort in this report, which verifies everything they know or have believed about the nature of the ADC problem in our metropolitan communities and the needs of ADC recipients, and recommends perhaps every change and improvement in administration they have been recommending. This reviewer believes both the report and the addenda should be required reading for all social workers, no matter what their connection with ADC. But even more important, and more impossible of realization: it should be required reading of all members of planning groups and boards of supervisors in metropolitan communities.

From the standpoint of improving the administration of ADC, this study—and remember, it is made by a national management consultant firm, not by social workers—is almost too good to be true. The one major criticism of the study report, as this reviewer sees it, is that it does not make absolutely emphatic that no amount of improvement of administration of the program as currently conceived will adequately deal with the pervasive social problems of which the incidence of ADC is only a symptom.

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ADULT EDUCATION AND TREATMENT GROUPS IN SOCIAL AGENCIES. By Joyce Gale KLEIN. Washington, D. C.: Catholic University of America Press, 1960. 213 pp. $3.50.

Although professionals in the field of social work have become aware of the increasing use of group methods as a part of the treatment process in casework settings, the body of professional literature has included little if any definitive study on the extent, variations, and objectives of this newly employed method. Joyce Klein's comprehensive examination and thoughtful appraisal of the caseworker's use of groups represents a real contribution to our knowledge of this growing phase of practice.

The study examines the adult client groups in the Washington-Baltimore area which were led by professionally trained caseworkers during the calendar year 1958. It is designed to test two major hypotheses: (1) that casework agencies are expanding their work in the community through the use of growth-oriented client groups, and (2) that the use of groups as a unit of service saves agency staff time and money. The data provide firm substantiation of the first assumption, and the author concludes that "there is a vigorous movement" for caseworkers to lead groups. The study further demonstrates that the use of such groups does not represent an economy of either time or money for the agency involved.

One of the principal values in an analytical study of this type is seen in the significant questions it raises about the possible future direction of social work practice. Mrs. Klein's material reveals that the vast majority of caseworkers involved in the leadership of client groups have a positive conviction about the value of group methods in achieving treatment goals. The strong testimony of the practitioners interviewed indicates that this current trend is destined to grow. It seems evident that the social worker of the future will face an increasing demand for skills to work with clients both individually and in groups. This implies a challenge to schools of social work and agencies who will share in the training and employment of a professional with greater breadth.

The field's immediate task is that of defining not only where we are going but how we intend to get there. Our present procedures as described in the study under review have obvious dangers in that the caseworker seems simply to take on the role of the group worker with no defined criteria for competence in the use of group methods. It is significant that only half the caseworkers who reported that they were engaged in leading client groups responded to questions about their knowledge of group process. The author noted a marked discomfort on the part of those who did reply, several of whom indicated that they worked from "intuition." To continue in this course would be wasteful trial and error at best, and could prove disastrous to the hapless client exposed to an emotionally explosive group under the guidance of a worker who has no professional skill in directing and limiting the group process.

The underlying plea of this study is for caution and deliberation. We are at the point of undertaking a significant step toward the development of a new treatment method. The potential for enhancing social work practice is great, but it will be lost if we proceed in a random fashion. Within the social group work field there is an accumulation of considerable knowledge about the dynamics of group process and the appropriate functioning of the group worker. This know-how must be incorporated into all social workers' practice with groups. An amalgamation must evolve through joint study, controlled experimentation, extensive research, and the formulation of sound working principles which may then serve as the basis for an expansion of practice. Mrs. Klein's careful study is a good beginning, for it points out some sound movement as well as some glaring weaknesses in our current trends and should serve to encourage other researchers to enlarge our knowledge further.

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THE ANATOMY OF PSYCHOTHERAPY: SYSTEMS OF COMMUNICATION AND EXPECTATION. By Henry L. Lennard and Arnold Bernstein, with Erdman B. Palmore and Helen C. Hendin, M.D. New York: Columbia University Press, 1960. 209 pp. $6.00.

A saga of patience and scholarship is embodied in this microanalysis of the enig-

matic social interaction called psychotherapy. The verbal aspect of it was subjected to a content analysis. The authors recognize that visual clues, gestures, the physical situation, and other variables are also part of the therapeutic communication process. They concentrated their efforts on one means of communication—a methodologically sound decision.

Their patience must have been sorely tried by the immensity of detail involved in recording what was said in the course of eight therapies—four therapists with two patients each—over a period of eight months. More than 500 sessions were taped. Research time, staff, and other resources were sufficient to subject only 120 to an intensive content analysis. This required the classification of more than 40,000 verbal propositions along several dimensions. The results of this painstaking task are reported in the aptly titled volume here noted.

The questions asked of the data were sociological. Are structural (contextual) patterns emerging, as therapist and patient continue to talk to each other over a period of time? Are there interaction patterns which show stability within a session or over a large number of sessions? Therapy was studied as an *informational* exchange system, in which it is important to know what kind of communication the patient wants to transmit to the therapist and what the latter wants to transmit to the patient in return. The authors also investigated the patients' role learning. One objective of therapy is to teach patients the role of being a "good patient" within the therapist-patient expectations system—an element which the authors call "deutero learning."

These sociological variables have one thing in common with psychodynamic ones: they exist largely outside the conscious awareness of the participants. Psychotherapy may have the stated goal of insight and self-control development of the patient to obtain his life's goals, but the book demonstrates that therapy can also be viewed as learning, as role training, as exchange of information, and as a social adjustment process. It contains such findings as that vague therapist statements (containing propositions of low information specificity) yield a greater number of patient propositions than do therapist statements containing propositions of high informational specificity. Patients also expressed more satisfaction with therapeutic sessions in which the therapist's verbal activity was highly structured. It is apparent that the therapist's action, not only the patient's inner needs, can affect the client's rate of output.

This sociological approach to the therapeutic interaction is as relevant to social casework as it is to psychotherapy. The theoretical frameworks within which these two helping processes are conducted probably differ more than their social structure. This is why the book is to be recommended for careful reading by social workers, although they should be warned: Do not tackle when tired!

Readers who expect findings of great practical significance to result from this enormous research effort, from the sophistication of its theoretical orientation, and from the operational specificity of its classificatory categories, will be disappointed. The book provides an imaginative system for describing the therapeutic process. It did not concern itself with the outcome of therapy. Nevertheless, an important breakthrough is made when something as complex as psychotherapy is broken down into well-defined variables that are meaningfully related to attitudes. *The Anatomy of Psychotherapy* adds to our kit of conceptual tools for maximizing the systematic analysis of the therapeutic process. Studies of what does or does not contribute to the effectiveness of therapeutic interventions can only be made when we are able to describe the variable.

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THE INFORMED HEART: AUTONOMY IN A MASS AGE. By Bruno Bettelheim. Glencoe, Ill.: The Free Press, 1960. 309 pp. $5.00.

This is an unusual and important book. It pushes forward the frontiers of our technical information concerning personality changes in relation to social experiences at the same time as it gives deepened understanding of the individual in a mass age. Drawing upon his personal experience as a prisoner in the concentration camps of Dachau and Buchenwald, Dr. Bettelheim illustrates through description of the responses to coercion and the defenses used by the prisoners against brutality that people retain possession of themselves only as they retain some area of autonomy, of ability to make a choice, even if the choice is death.

The book suggests in broad strokes the evolution of his own theories of personality change and treatment theory. He has moved from the traditional psychoanalytic treatment, as it developed within a relatively stable European society, to a milieu treatment based upon classical analysis—only to learn that "love is not enough," that when the subtle balance between the living environment, personality, and psychotherapy is not taken into account dynamically, psychoanalysis may be static or even harmful in its impact.

The first part of the book is devoted to a discussion of the theoretical implications of the author's study of adaptation to the mass state and to behavior under coercion. He discusses its significance for child growth and development, for treatment of disorganized individuals, and for understanding the effect of industrialization in reducing the sense of the importance of the individual. Although this is a difficult book to write, *The Informed Heart* is well written and organized.

Dr. Bettelheim's original article, based upon his studies of personality adaptation in concentration camps, the personality change, and its impoverishment or destruction both within and outside of the camps—in the prison population and in the neighboring "free" civilian population—became required reading for all United States military government officers in Europe. *The Informed Heart: Autonomy in a Mass Age* will be of interest to all social workers and all professions whose task is to help in the achievement of more satisfactory relations between man and man. It is also of interest to all citizens of a free society, and to elected officials whose task it is to understand not only the onslaught of modern authoritarian political systems, but to recognize the more subtle and insidious threats to personal freedom and individuality.

While Dr. Bettelheim's presentation presupposes familiarity with psychoanalytic concepts, much of the book is suited to a nonprofessional audience. A chapter relating to the lesson of *The Diary of Anne Frank* appeared in a recent issue of *Harper's Magazine*. Despite the horror of his personal experiences, Dr. Bettelheim is optimistic. He believes that it is possible for a people to achieve an increasingly higher integration, individually and as a society, in a mass age.

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A STUDY OF NON-PROFESSIONAL PERSONNEL IN SOCIAL WORK—THE ARMY SOCIAL WORK SPECIALIST. By Fergus T. Monahan. Washington, D. C.: The Catholic University of America Press, 1960. 201 pp. $3.25.

Factors related to "whether or how" nonprofessional personnel might be effectively integrated into professional social work programs have been the subject of much interest and discussion by social workers and their agencies and organizations.

This study, "exploratory and descriptive," is an initial contribution of system-

atically accumulated knowledge in this area. Its primary purpose is to describe salient features of the performance of nonprofessional personnel (social work specialists) on the staffs of seven Army mental hygiene consultation services. In addition, the author tests several observations stated as hypotheses developed from social theory, relating to: (1) the status and role of nonprofessional staff, *i.e.,* the extent to which status attributes of reward, prestige, authority, and functional importance are congruent to their work position; and (2) the performance of social work specialists based upon (a) the manner in which they are perceived by using agencies, (b) the position of importance assigned to them and their tasks, and (c) the specialists' own tendency to deprecate the less glamorous features of their work and focus on the most highly valued element in the consultation service subculture, *i.e.,* care of the patient. These considerations should be thoughtfully evaluated as they relate to any existing or planned program involving nonprofessional staff aides.

The primary subjects of this study are thirty-two social work specialists assigned to seven Army mental hygiene consultation services. (The variations in their military rank and their consequent hierarchical status in the clinic may be considered to be roughly equivalent to the structure in similar civilian agencies as defined by position rating or title, job description, etc.)

Writing in formal style, the author employs the sound research methodology required of a doctoral dissertation in the selection of his sample, development of his theoretical formulations and observations, and collection of data. The method of data analysis, however, is inferential rather than statistically precise. The data include descriptions of the specialists' positions and performance by the specialists themselves, as well as by twelve professional social work officers and ten Army psychiatrists who are in positions of authority in the seven clinics. The definition of nonprofessional personnel as presented requires further refinement and clarification before any inferences can be legitimately drawn from these data—for example, three graduates of accredited schools of social work are included in the sample of nonprofessional personnel.

While congruity was generally found to exist among professional staff relative to the mission of social work within the mental hygiene consultation service, these opinions were not uniformly shared by social work specialists. The reported tendency of a significant number of specialists to identify their function as assisting the more prestigeful profession of psychiatry suggests a lack of conceptualization and appreciation of the role of social work in an interdisciplinary relationship.

However, considerable agreement is reported among all the subjects of this study on the duties these specialists do (and presumably should) perform. These are: "*intake interviewing* (obtaining data about the present problem, learning about the patient's past life experience, and discussing the results of the interview with either the social work officer or the psychiatrist); *collateral contacts with unit personnel* (obtaining additional data about the patient, assisting unit personnel better to understand the patient, and reporting information about the unit's social structure to the MHCS professional staff); *clerical and military duties.* In addition, specialists were reported to be providing *counseling* and *patient related duties* by most respondents except at two posts where counseling was not permitted."

The four observations (hypotheses) presented by the author are for the most part upheld by the data.

This study should be interesting reading for social workers who would integrate nonprofessional staff into professional programs. To them it offers an exploration of a program which has utilized nonprofessional staff over a seventeen-year period and presents for critical review many con-

siderations inherent in such program development. Many social workers may share this reviewer's feeling of the importance of what is implied in the study, namely, that nonprofessional staff can and does perform effectively in the areas described with supervision by a social work officer.

This study is a timely and provocative piece of research by a social worker in an area of import to the whole profession. If it serves to stimulate the application of precise research techniques to measuring the effectiveness of nonprofessional staff, it will have served a useful purpose.

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HANDBOOK OF SOCIAL GERONTOLOGY—SOCIETAL ASPECTS OF AGING. Edited by Clark Tibbitts. Chicago: University of Chicago Press, 1960. 770 pp. $10.00.

The Gerontological Society, Inc., with the assistance of a grant from the National Institute of Mental Health made to the University of Michigan Institute for Human Adjustment, Division of Gerontology, collaborated in bringing forth this handbook which represents a first attempt to identify and structure a new field of research and learning, that of social gerontology.

Social gerontology separates out (1) the phenomena of aging related to man as a member of the social group and of society and (2) those phenomena which are relevant to aging in the nature and function of the social system or society itself.

The *Handbook of Social Gerontology—Societal Aspects of Aging* is a collection of contributions from nineteen individuals who come from a variety of disciplines including sociology, economics, religion, health, labor, anthropology, and housing.

The intent of the handbook is to bring us a guide to research for groups interested in the societal aspects of aging. It is organized into three parts. Part One deals with the basis and theory of societal aspects in aging and in a sense provides a framework for the book as a whole. It also traces approaches to the aging in preindustrial societies up to the present date. Part Two deals with the effects of biological and psychological aging, of changes in health and income status, and of technological and sociocultural influences on the position, roles, and behavior of middle-aged and older people. Part Three concerns itself with the aging and reorganization of society. It shows how changing institutions affect the environment of old people and points the ways in which institutions and organizations may be modifying their structures in response to the aging population.

This handbook can be considered a major contribution to the field of social gerontology and social research. Its selection of contributors is noteworthy, and much credit is due the editors and others who were instrumental in compiling this work. Along with the *Handbook of Aging and the Individual* edited by Dr. James E. Birren of the National Institute of Mental Health, it makes a pair of volumes that would be essential for any gerontological research.

The *Handbook of Social Gerontology* should hold special interest for family agencies and institutions where the particular emphasis of service is on the aged, because of the major step forward in avoiding premises based on stereotypes. Schools of social work would do well to include this handbook as a requirement for graduate students in social casework and group work, since it is an excellent contribution not only to the field of social gerontology but to social research as well. To the student this book should offer much by way of presenting a sound base of facts, and to the practical social researcher the basis for a number of questions in yet unexplored areas. It establishes guidelines with ex-

cellent bibliographies and protocol for research in this field.

The reviewer feels that the handbook is the first attempt at a comprehensive approach on a sound scientific basis to a field which is just coming of age.

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THE LEAN YEARS. By Irving Bernstein. Boston: Houghton Mifflin Company, 1960. 513 pp. $7.00.

The Lean Years is a history of the effects of government, business, and union policies on the lives of American workers in the crucial years 1920–1933. The book forms part of the research program of the Institute of Industrial Relations of the University of California in Los Angeles. The author has drawn upon a wide range of resources: official records, economic and social studies, and personal papers. He has enlivened the narrative with the kind of picturesque detail that makes a heavy volume easy as well as interesting to read—for example, the words of the bitter songs of the miners in Harlan County, Kentucky; interpretative portraits of such personages as John L. Lewis, John D. Rockefeller, Jr., Robert Wagner, William Green, and President Hoover; vivid descriptions of the routing of the bonus army from Washington and of the Ludlow massacre.

To workers these years were characterized by long hours (when work was available), low wages, and lack of protection against the hazards of illness, unemployment, and old age. Repression, starvation, and even death were the price often paid for trying to organize—whether by inexperienced textile workers from the back hills of the South or experienced miners facing the shutdown of coal mines no longer economically useful.

To the privileged few, however, these were golden years when employers enjoyed almost unchallenged power and stocks were high. The "American Plan" and the company union were widely heralded, but always in the background were the injunction and the yellow-dog contract to keep workers in their place. The employers who dealt with the unions of the workers' choice and who stood out against repressive measures were conspicuous—and brave.

The specter of unemployment that haunted workers all through the twenties finally stalked through the whole of society until the spring of 1933, when one out of three workers was jobless, and the nation was on the verge of collapse. The "modest program" that tried to offer morale instead of bread and jobs had failed. It is hard to realize today that during this period the collection of reliable data on unemployment had barely begun; there was no national system of employment offices, and until 1932 no federal assistance to states for relief on any sustained basis. In literal starvation and paralysis of normal social functioning, the price was paid for the administration's theory of local and voluntary responsibility unaided by the resources of the federal government. Proposals for federal programs were developed by economists, social workers, legislators, and labor leaders to be taken up later at the advent of the New Deal.

The Lean Years provides a valuable slice of history for social workers, reminding us as it does of the human cost of government and business policies based on inadequate social data and remote from the experience of workers. In any era of history there lurks the danger of failure to recognize and deal with social problems before they result in catastrophe.

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THE DISEASE CONCEPT OF ALCOHOLISM. By E. M. Jellinek. New Haven, Conn.: Hillhouse Press, 1960. 246 pp. $6.00.

Social workers who are beginning to show an interest in the possibility of using their skills to help alcoholics will find in this book an excellent starting place. The approach to alcoholism by a variety of helping professions that have proved their methods in other areas is unique when they rather suddenly take a serious look at a problem that has been previously ignored as a treatable human difficulty. Dr. Jellinek's book says, in essence: Here is where we now stand in our knowledge and beliefs about alcoholism.

Social workers who have been a part of this new approach to an old problem will find in the book an excellent over-all view of the forest whose trees represent their immediate professional environment. It will remind these workers where they have come in this venture and help them in planning where they should go.

Jellinek has been a pioneer in the alcoholism field, but—unlike too many pioneers—he has stopped to take stock of progress and to put into writing a picture of the *status quo*. His book stands alone in its field and will in the future mark clearly the history of a new attack on an old problem.

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EDITOR'S PAGE *(Continued)*

potatoes or peanuts sent to others during the depression. But on the whole, we knew better even then and both at home and abroad we often succeed in making relief effective. The proven "law" is that relief, unaccompanied by technical assistance, family services, and related efforts toward rehabilitation, is of comparatively little value.

While social work is "shook up" about its contribution to the larger welfare scene is perhaps a good time to look at the smaller problems that plague most institutions and agencies. What about these new welfare classifications and what is happening to the class at the bottom? Are voluntary family agencies closing intake or refusing difficult cases without research and better community planning? Are adoption agencies charging all the traffic will bear and substituting the Hollywood and Park Avenue client for the underprivileged? Does this mean that the great principle, that in adoption placement the child is the first consideration, is set aside? Are CO planners accepting a welfare pattern of coexistence? If coexistence isn't good enough as a goal abroad, is it good enough to replace social work's many notable achievements in collaboration at home? How much authoritarianism in the administration of service and community planning agencies still exists? How sturdy are our personnel practices and democratic processes for policy making?

It cannot be denied that social work has been more successful in reaching the *victims* than the *leaders* in the power struggle. If we have not done as much as we should on segregation, we have certainly not been idle, but here is another place where we should scrutinize agency practices in the most "enlightened" communities. The group service agencies have a pretty good record on multicultural participation. Is it not time for a frank report and reaffirmation of the faith that is still in us? Social work has modified many of the cultural and economic structures in the American scene. We could justifiably give ourselves a great deal of credit for putting the family into the center of the health and decency picture. That social workers want to bring in the welfare state in the sense that welfare may be shared by all citizens should be proudly admitted. And if Sir Geoffrey Vickers, speaking at the first Canadian Conference on Children, is right that the world, if it survives at all, will be both socialized (not socialist) and colored, let us be the first to say that we are not afraid of either eventuality.—G. H.